Response to California's
Draft Dual Eligible Demonstration Request for Solutions
Issued By the Department of Health Care Services December 22, 2011

Demonstration Goals (Page 6)

We believe that one of the goals of a demonstration should be to test various models to provide maximum learning to the State and stakeholders concerning what models work best for this population in this state. For example, we would have liked to have seen some sites use passive enrollment and others use a voluntary enrollment model since we have so much disagreement over this issue within the stakeholder community. By structuring this solicitation so as to place the design of the models to be tested in the hands of health plans to the degree proposed is not likely to produce this type of variation. Also, we do not believe that the State should be limiting the demonstration to existing Medi-Cal Managed Care plans, as is proposed. We would suggest that at least one site be in a non-managed care area, as that will require a very different model that needs to be developed to provide coordinated care in significant areas of the state.

At this point, we would urge this section to be modified to expressly indicate one of the goals is to test different approaches to the design and implementation of key aspects of these demonstrations, including different enrollment models.

Demonstration Population Page (7)

The document specifically requests comment on whether the demonstration should exclude beneficiaries who have been institutionalized for more than 90 days. We believe the incentives for cost-effective, coordinated care and supports will only be achieved by placing the integrating entity at full financial risk for all the health care and long-term services and supports the person may receive. The integrating entity needs to be fully at risk for the most expensive settings – hospitals and nursing facilities – in order to have the incentive to be aggressive and creative in providing the supports that enable people to live in the home or community, the settings most people prefer. **This incentive should not be muted by placing limits on the liability of the integrating entity for these expenses**. **Placing a 90 day limit on the liability of the integrating entity changes the equation when considering the cost-effectiveness of providing the supports necessary for a person to live in the community. Instead of comparing the costs in the two settings for comparable periods, the comparison would be between the costs of**

Contact: Casey Young: cyoung@aarp.org/916-556-3010

institutionalization for 90 days vs. the costs of ongoing support in the community with no end date. It will create a severe bias towards institutionalization. It will also eliminate any incentive to transition persons now in nursing facilities into the community. This would be a serious mistake.

It has been orally explained subsequent to the issuance of this document that what is actually being considered is that persons who have been institutionalized for longer than 90 days (not counting time a person has been in a nursing facility covered by Medicare) will be excluded only for the first year, and that liability for the cost of institutionalization will otherwise be fully borne by the plan or other integrating entity. If that is the case, this is less of an issue, and we would suggest that, given the importance of this issue, the final RFS be very clear about the limitations of the exclusion.

Enrollment (Page 7-8)

As previously indicated, the question of whether a site will use passive enrollment should not be entirely within the applicant's prerogative. This is an issue that needs to be tested. To ensure that there are some sites with this feature and some where beneficiaries opt in rather than are automatically enrolled, only some of the sites should be permitted to use passive enrollment.

Also, we strongly believe that there should be no 'lock-in" of six months or any other period, as is apparently being contemplated in the RFS. The best early indicator of problems is the frequency of disenrollment in a plan. This should be tracked closely so that early problems can be identified and addressed quickly. Preventing people from disenrolling eliminates this important tool to make early course corrections.

Also, one of the lessons being learned from the 1115 Waiver experience is that it is a mistake to transition people because it happens to be their birthday month, a strategy the RFS invites applicants to propose. This prioritizes moving large numbers of people into a new system quickly over moving people as the necessary work has been done to ensure a smooth transition. There clearly needs to be more analysis concerning how to best create systems and processes so that there is a much warmer hand-off into the new system and much fewer surprises on the part of plans, providers, and consumers. The transition of individuals should be scheduled as the in-person assessments can be arranged with all the persons necessary to assess their medical, behavioral, social and long-term service and support needs so a comprehensive plan can be developed and implemented. Transitions should not be scheduled simply because a date on the calendar has arrived.

Geographic Coverage (Page 8)

This is going to be a very complex, difficult population to transition into a new system in which behavioral health and long-term services and supports is integrated with acute and chronic medical care. This is new to plans, counties and stakeholders, and the risks to this vulnerable population are significant. We would suggest another dimension should be added to the indication in this section that sites must be capable of covering the entire population of dual eligibles in a county. It is equally important that this be done on a manageable scale, knowing that mistakes will be made and adjustments will be necessary as everyone learns. There are some counties (San Mateo and Orange are most often cited) that have been working towards the goals of this demonstration for many years and are probably much more ready than others. Given the timeline for this demonstration, however, any large sites that are just starting to think through the integration issues and develop the necessary relationships are not likely to be successful and should not be considered.

Integrated Financing (Page 8)

In the demonstration sites to be administered by health plans on a capitated basis, it is critical that the rates be sufficient to fund the benefits and administration without risking the quality of care and services provided under the demonstration. We urge that the state be very transparent about the assumptions in the model generating the rates and the rationale for those assumptions. It is important that we know the expectations concerning the cost and utilization of the various services in order to both understand what is expected under the demonstrations and to assess the results against those expectations. **The indication in the RFS that rates will provide less than is currently being expended on this population prior to any analysis of the experience under these new, untried, yet-to-be-designed models is of great concern.** Providing quality care to this very vulnerable population should be ensured before taking money out of the system.

Benefits (Page 8)

This section indicates that the demonstration sites must demonstrate adequate capacity to provide seamless access and coordination of services based on the needs of the enrollees across the full continuum of services from medical care to LTSS. We believe it is critical that this be based not only on the needs, but the preferences, of enrollees. This is particularly critical in long term services and supports, where the types of services and supports will determine where and how the person will live.

We strongly urge that the only applicants considered should be those proposing a person-centered assessment and care planning process that elicits the desires of consumers, bases

the care plan on the results of such a process, and evaluates the experience of the consumer on an ongoing basis. The Personal Experience Outcomes - Integrated Interview and Evaluation System (see http://chsra.wisc.edu/peonies) used in Wisconsin is the type of system we believe should form the foundation for LTSS assessment, care planning and evaluation to assure consumer preferences drive decisions concerning what services and supports will be provided.

IHSS (page 9)

It was very disappointing the see this section. We have for months been pointing to IHSS integration as a key issue that needed considerable attention in designing this demonstration. As currently written, this section signals that the intent is not to integrate IHSS but to eliminate it and ask health plans – who have no experience in this area – to design a replacement.

Knowing the timeline for this demonstration, we would at this point suggest that this section be rewritten to indicate that the existing IHSS program will be used to provide home care services under the current structure for the duration of this demonstration, and sites will need to enter a contract with the county for the administration of these services under existing rules.

Care Coordination (Page 9)

We would suggest that language be added to this section clearly indicating the need for a tool such as the Personal Experience Outcomes - Integrated Interview and Evaluation System (see http://chsra.wisc.edu/peonies) to assure consumer preferences drive decisions concerning what services and supports will be provided.

Beneficiary Notification (Page 9)

One of the clear learnings from the 1115 waiver experience with the SPD population is that there needs to be a much better job of informing beneficiaries of their options and helping them make choices. This population is even more fragile and vulnerable and is going to need more help. In addition to the alternative formats promised not materializing, the packets of information provided to potential enrollees were large, dense and not very helpful in assisting beneficiaries to make choices, as reflected in the very high default rates.

In addition to substantially improving the materials for this population, **we believe it is critical to provide this population independent choice counseling** similar to that provided to seniors by the Health Insurance Counseling and Advocacy Program (HICAP).

Network Adequacy (Page 10)

The most significant difference in the networks necessary to serve this population and the networks for the SPD population being enrolled in managed care plans now is the network of long-term services and supports, something that is foreign to most Medi-Cal managed care plans, as well as state regulators. While DHCS could and did turn to DMHC to assist in the analysis of the adequacy of health care networks for the SPD population, neither agency has expertise in assessing the adequacy of networks to provide LTSS services to the population to be served under this demonstration. The RFS seems to suggest that there are Medi-Cal standards for LTSS network adequacy, but on questioning it has been clarified that this is still on the to-do list. It is very important to get this right for the dual eligible population, which is another reason to have demonstration sites that are of a manageable size, to maintain the existing IHSS program for the duration of this demonstration, and to use only sites where there is a strong, well-organized LTSS community. The prospect of the adoption of last-minute LTSS network standards, coupled with sites administered by plans that have no history of providing LTSS or interacting with LTSS providers in the community, is very concerning.

Quality Incentives (Page 10)

We have been told the quality objectives to be used to earn back withheld capitation revenue have not yet been determined. We would suggest that one of the measures be the extent to which beneficiaries needing long-term services and supports have their preferences honored, as measured by the Personal Experience Outcomes - Integrated Interview and Evaluation System (see http://chsra.wisc.edu/peonies).

Criteria For Additional Consideration (Page 16)

We would suggest adding:

- Existence of a draft Agreement or Contract with the local Aging and Disability Resource Center (ADRC), or if there is no ADRC in the locality with existing local entities performing similar functions in the community, demonstrating significant steps in the development of a formal agreement with an entity or entities with significant knowledge of and experience with long-term services and supports providers in the community.
- Existence of a draft Agreement or Contract with the local Area Agency on Aging, demonstrating significant steps in the development of a formal agreement to coordinate or provide Older Americans Act services that are designed to maintain older persons in the community.

Current Medi-Cal Managed Care Plan (Page 18)

As indicated previously, we believe this demonstration should not be limited to Medi-Cal managed care plans, but should be open to entities that are prepared to demonstrate how the goals of this demonstration can be implemented in a more rural area where existing managed care plans do not operate. We have seen such models in other states (e.g., Community Care North Carolina) and this seems to be an ideal opportunity to encourage the development of such a model in this state.

Countywide Coverage (Page 19)

This section indicates that successful applicants will need to demonstrate the ability to "cover" the entire dual eligible population in a county. That is fine as far as it goes, but it is very unclear what this means. If it simply means that the plan and its partners are authorized by DMHC to provide medical coverage in all the zip codes in the county, it does not go nearly far enough. The coverage needs to extend to all the long term services and supports that are going to be provided in this demonstration as well. As previously indicated, there are no LTSS network standards now so it is not clear what standard they would be held to in the 3-4 weeks between the release of the final RFS and the date the applications are due. At a minimum, however, applicants should be required to indicate how they are going to cover LTSS, as well as medical care, for this population throughout the county.

Americans with Disabilities Act and Alternative Format (Page 19)

This section requires applicants to develop a plan to "encourage" its contracted providers to fully comply with the ADA. Encouraging is not enough. In this section the state should set forth the requirements for an accessible provider network with which applicants will need to comply to be considered in this demonstration. It may be that every contracted provider needs to comply; it may be that the network must have a certain number or ratio of contractors who comply. But as written, there is no standard other than that the applicant is to "encourage" compliance by contracted providers. There needs to be more certainty for the benefit of applicants as well as disabled beneficiaries.

Stakeholder Involvement (Page 20)

We believe that a history of meaningful stakeholder engagement should be demonstrated as a condition of the application being considered. Relationships and trust are only built over time, which are going to be important to a successful demonstration.

Section 2.1: LTSS Capacity (Page 23)

The second bullet contemplates that the applicant is going to determine the reimbursement of LTSS providers. We believe this is a mistake. In order to have an adequate network of providers for consumers, it is critical that the reimbursement from the integrating entity be adequate to provide quality care and services. For at least the basic services (medical, hospital, skilled nursing, adult day health centers, home care), this should not be left to negotiations between providers and the integrating entities, which would have various degrees of negotiating leverage in different geographic areas. For the most part, there are reimbursement levels for medical and long- term services and supports that the state has adopted, or could adopt by reference, to remove this potential source of instability. Particularly for demonstration pilots, the state should be exploring the potential benefits of utilization management, not the potential for cost savings through reducing provider reimbursements to the point of risking quality care and services.

Section 2.2: IHSS (Page 24)

The second section contemplates the transition of IHSS services to a new model developed by the participating Medi-Cal managed care plans. As indicated previous, we believe this is a mistake. IHSS should remain as is for the duration of this demonstration.

Section 5.1: Consumer Choice (Page 25)

Consumer choice is the most important attribute that needs to be built into this demonstration, particularly when it comes to LTSS:

- Choice of Plans – Where services for dual eligibles are to be administered by a managed care organization, there should be, at a minimum, a choice of at least two fully qualified plans from which they may choose. This is a requirement imposed by CMS in the terms and conditions for the enrollment of Seniors and Persons with Disability in any non-COHS county under the 1115 Waiver, and should be a condition for any demonstration site under this project. Even in COHS counties, preference should be given to sites where the option of a PACE program is also available to clients. Independent choice counseling should be provided to assist individuals make the best decision for their situation. As previously indicated, there should be no 'lock-in" of six months or any other period, as is apparently being contemplated in the RFS. The most important consumer protection is the ability to leave a plan that is not serving the consumer's needs.

- Passive Enrollment – We prefer that individuals affirmatively choose to enroll in one of the plans being offered under the demonstration. Plans should be incentivized to make the offer attractive enough to encourage a sufficient number of individuals to

enroll. We also understand that there are concerns about whether inertia will effectively result in most individuals choosing the status quo. As indicated above, we would suggest that this is something that the state should seek to test in this demonstration, requiring some sites to have voluntary enrollment and others passive enrollment. Where passive enrollment is permitted, the state needs to ensure that consumers have timely, adequate information to provide a real choice to opt out of the plan if they choose to do so.

- Choice of Long-term Care Settings – Consumers needing long-term supports and services can potentially receive them in a variety of settings. This may include nursing facilities where a person receives skilled nursing services in a facility where they reside, Adult Day Health Centers where similar services are available only during the day, or at home where many services can be provided by in-home supportive services workers. The consumer should have the choice as to what setting is most appropriate under the circumstances. I would note that while AARP and other consumer representatives have historically pushed very hard to enable consumers to receive services in their home or the community, which we know most would prefer, once an integrating entity has financial responsibility for all types of medical and long-term services and supports we begin to worry about the barriers that may be erected to access to more expensive options, including nursing facilities for which the consumer may be eligible. Consumers' situations will differ in many respects, including their abilities, caregiver supports, and preferences. The choice of the setting in which services are provided should be a decision made by the consumer.

- Choice of Provider – Consumers should have a reasonable choice of all types of providers. In the case of home care workers providing personal care services, consumers should have the ability to hire, fire, schedule and supervise their provider, and should be continue to have the option to hire family members to perform these services.

TO: Director's Office – Department of Health Care Services

RE: Comments To the Draft RFS for the California Dual Eligible's Demonstration Project

Dear Director:

Thank you for the ability to provide our comments and suggestions on the Draft RFS noted above. We appreciate the gravity and importance of this project and as a current provider of IHSS services in California, are happy to have the opportunity to comment. We believe the utilization of IHSS as well as a full complement of community based supportive services such as nutritional support, telephone reassurance, adult day services, transportation etc are essential to achieving positive Consumer and meaningful fiscal outcomes and our encouraged that the RFS places significant importance on these services. After review of the draft document, we have the following comments and questions.

Page 12 – Network Adequacy: this section references "Medi-Cal standards for network adequacy for LTSS". Can DHCS provide these standards or provide a reference as to where these can be found.
Page 28 – Section 5.5: Enrollment Process Are there benchmarks for enrollment percentages?
Page 29 – Network Adequacy: asks that the applicant certify that the goals of the program will "not be weakened by sub-contract relationships of the Applicant". As applicants may be insurance companies that are not direct service providers, they will certainly have to subcontract in order to provide the necessary programs. Can DHCS please clarify the goal of this certification and more specifically outline what would constitute "weakening" of the program's goals.
Additionally, the RFS does not provide any information related to how these responses will be evaluated, by whom and what the scoring methodology will be. It would be helpful for Applicants to know what sections of this proposal carry more weight than others so they may focus their responses.

Again, we appreciate the opportunity to provide our comments and look forward to being involved in the progression of this process. Feel free to contact us for any additional clarifications.

Diane Kumarich RN, MS, MBA
VP National Contracts and Acquisitions
Addus HealthCare, Inc.
2401 S. Plum Grove Road

January 9, 2012

Department of Health Care Services (DHCS)
Procurement Office
Via email OMCPRFP9@dhcs.ca.gov

RE: Draft Request for Solutions (RFS), California Dual Eligibles Demonstration Project

Dear DHCS Staff,

Thank you for the opportunity to comment on the Department's draft RFS for California's Duals Project released on December 22, 2011. Your public engagement process has been exemplary and can serve as a model for other California reform initiatives and pilot projects.

We wish to express our support for the inclusion of technology, and eCare technologies in particular, into the Key Attributes (page 11) and in the Project Narrative, Section 7.2 (page 30). The Duals Project presents an important opportunity for innovation and to demonstrate the benefit of such technologies to help the State achieve personalized and coordinated health and long-term care services that result better health and independence for older adults and those living with chronic illness.

Point-of-care and health information technologies enable better care coordination, consumer connection to providers and streamlined communication. Telehealth improves access to critical care (tele-ICU, tele-stroke, etc.), specialty care (tele-dentistry, wound-care, etc.), and chronic care management (home telehealth, remote monitoring). These and other "eCare" technologies improve prevention and access to care, enable responsive real-time services, and increase staff efficiency, as well as empower self-health management by enrollees.

Moreover, there is mounting evidence that technology-enabled remote health monitoring yields significant cost savings. For example, if substantially utilized with the dual eligible population and other Medi-Cal enrollees with disease groups such as chronic heart failure, diabetes and COPD, home telehealth could result in $1 billion of savings for the state. Recent research published in Health Affairs shows cost savings from a CMS Telehealth Demonstration, and a recent report on the application of such technology-enabled models describes how the aforementioned cost savings can be achieved in Medi-Cal (*documents attached*).

It is fortunate that the implementation of the Duals Project follows the recent enactment of AB 415, the *Telehealth Advancement Act of 2011*, which makes several important updates to the California Telemedicine Act of 1996. The Telehealth Advancement Act supports a much broader and beneficial utilization of modern telehealth technology across California's spectrum of Medi-Cal health care services. Updates in the definitions of telehealth, allowable settings, and eligible health

care providers lay the foundation to enable the appropriate use of telehealth to better meet the care needs of Californians of any age, including older adults. The Act also supports the use of telehealth by health plans operating in California. These provisions make telehealth a viable tool available to providers to give the best possible care to Californians enrolled in health plans.

We recommend the following edits to the technology provisions in the Key Attributes and Project Narrative as follows (edits in underline):

Key Attributes:
Technology: Coordinated care will increasingly depend on the effective use of eCare technology, such as telehealth-enabled critical and specialist care, home telehealth technologies (i.e. daily health vitals monitoring, medication optimization, care consultations), remote monitoring of activities of daily living, and safety technologies. Demonstration sites are encouraged to include such technologies in their models.

Project Narrative:
Section 7.2: Technology
The Applicant must:
• Describe how your organization is currently utilizing technology in providing quality care, including efforts of providers in your network to achieve the federal "meaningful use" health information technology (HIT) standards.
• Describe how your organization intends to utilize care technology in the duals Demonstration (such as telehealth, remote health vitals and activity monitoring, care management technologies, etc).
• Describe how technologies to be utilized meet information exchange and device protocol interoperability standards (if applicable)

We believe that a sustainable paradigm of health care, especially health care for California's rapidly growing older population, requires service delivery models that incorporate eCare technologies. ***We commend the Department on including such technology provisions in the Duals Project, and urge your inclusion of these elements in the Department's final RFS.***

Sincerely,

Scott Peifer, Executive Director
AgeTech California
speifer@agetechca.org
(916) 842-7341

Chuck Parker, Executive Director
Continua Health Alliance
chuck.parker@continuaalliance.org
(503) 619-0867

David Lindeman, Director
Center for Technology and Aging
dlindeman@techandaging.org
(510) 285-5686

Mario Gutierrez, Executive Director
Center for Connected Health Policy
mariog@cchpca.org
(916) 285-1858

About AgeTech California

AgeTech California was established to promote the use of advanced health and wellness technologies by aging services and home care providers throughout California. Its primary focus is on technologies that enable older Californians' aging in "connected independence" with safety and security, personal health maintenance, successful management of chronic disease, early detection of illness, and prevention of acute episodes. Such technologies include telehealth, electronic health records, sensor telemonitoring, remote medication management, safety technologies, and cognitive fitness among others that enable eCare and personal wellness while enhancing caregiving and cost efficiency. AgeTech is a programmatic partnership of Aging Services of California and the California Association for Health Services at Home (CAHSAH).

1315 I Street, Suite 100
Sacramento, CA 95746
www.agetechca.org

About Continua Health Alliance

Continua Health Alliance is a non-profit, open industry organization of healthcare and technology companies joining together in collaboration to improve the quality of personal healthcare. With more than 230 member companies around the world, Continua is dedicated to establishing a system of interoperable personal connected health solutions with the knowledge that extending those solutions into the home fosters independence, empowers individuals and provides the opportunity for truly personalized health and wellness management. Founding members include BodyMedia, Cisco Systems, GE Healthcare, IBM, Intel, Kaiser Permanente, Medtronic, Motorola, Nonin Medical, Omron Healthcare, Panasonic, Partners HealthCare, Polar Electro, Royal Philips Electronics, RMD Networks, Samsung Electronics, Sharp, The Tunstall Group, Welch Allyn and Zensys.

3855 SW 153rd Rrive
Beaverton, OR 97006
www.continuaalliance.org

About The Center for Technology and Aging

The Center for Technology and Aging was established to support more rapid adoption and diffusion of technologies that enhance the independence and well-being of older adults. Through grants, research, public policy, and development of practical tools and best practice guidelines, the Center serves as an independent, non-profit resource for advancement of patient-centered technologies that improve the quality and cost-effectiveness of health care services. The Center identifies promising strategies to help health care organizations implement beneficial technologies in the areas of medication optimization, telehealth and remote monitoring, and mHealth, among others. The Center for Technology and Aging is a center of excellence at the Public Health Institute and was established with support from The SCAN Foundation.

555 12th Street, 10th Floor
Oakland, CA 94607
www.techandaging.org

About the Center for Connected Health Policy

The Center for Connected Health Policy (CCHP) is a non-profit planning and strategy organization working to remove policy barriers that prevent the integration of telehealth technologies into California's health care system. CCHP conducts objective policy analysis and research, develops non-partisan policy recommendations, and operates telehealth demonstration projects. CCHP works to identify and promote practice pattern, policy, regulatory, and statutory change that will maximize the ability of telehealth to improve health outcomes and care delivery and hopes to make California a national model for robust integration of telehealth technologies. CCHP is a program of the Public Health Institute (PHI) and receives funding support from the California HealthCare Foundation (CHCF) and the California Endowment.

1331 Garden Highway
Sacramento, CA 95833
www.connectedhealthca.org

aging services of california®
Advocating Quality Senior Living and Care
A Partner of LeadingAge

January 9, 2012

Mr. Peter Harbage, President
Harbage Consulting
c/o Department of Health Care Services
Office of Medi-Cal Procurement, MS 4200
P.O. Box 997413
Sacramento, CA 95899-7413

Via email: OMCPRFP9@dhcs.ca.gov

RE: Comments on Draft Request for Solutions for California's Dual Eligibles Demonstration Project

Dear Mr. Harbage:

Thank you for allowing Aging Services of California the opportunity to comment on the Request for Solutions (RFS) document released on December 22, 2011. The efforts to involve stakeholders in this process has been impressive.

Aging Services of California is the state's leading advocate for quality, nonprofit senior living and care. The public-interest association's more than 400 members across the state include providers of affordable senior housing, residential care facilities for the elderly (assisted living), continuing care retirement communities and skilled nursing care. Aging Services members serve the needs of approximately 80,000 seniors. While Aging Services is generally supportive of the RFS document, there are a few areas of concern that are detailed below:

Page 25, Section 2.1: LTSS Capacity

Aging Services of California requests that "Residential Care Facilities for the Elderly (RCFEs)" be struck from the list of providers included in the "institutionalized" settings:

- Describe relevant experience with individuals living in group homes, ~~Residential Care Facilities for the Elderly (RCFEs),~~ Intermediate Care Facilities (ICF-DD, ICF-BH), Congregate Living Facilities (CLF) or other type of "institutionalized" settings.

Residential Care Facilities for the Elderly (RCFEs) are included in the RFS' list of provider types characterized as intuitions. RCFEs ***are*** home- and community-based settings that offer care and supervision to residents who need it. These are voluntary housing choices and not medically oriented. RCFEs cover a gamut of configurations from small 6-bed "board and care" facilities to amenity rich independent living communities such as Continuing Care Retirement Communities (CCRCs). This

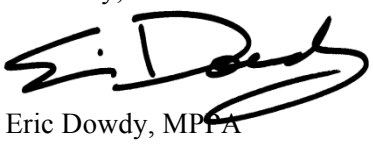
"social model" of community-based living should be encouraged under the dual eligibles integration, not treated as institutions. Aging Services strongly believes it is inappropriate to include RCFEs on the list of "institutionalized settings."

Page 10, Program of All-Inclusive Care for the Elderly (PACE)
Aging Services of California strongly supports the inclusion of PACE services as a separate and distinct program for the dual eligible population. We believe that PACE should be offered as an option to beneficiaries and included in all enrollment materials and outreach efforts. Further, we support providing managed care plans with the ability to refer eligible beneficiaries to PACE and that these beneficiaries have the ability to disenroll from plans and enroll in PACE at the point they are eligible, prior to entering a nursing home.

Page 11, Techology
Aging Services of California strongly endorses efforts to incorporate eCare technology into the selection criteria. Technology holds great promise to improve care for dual-eligible population and create efficiencies and cost savings for the state.

If you have any questions or comments, please feel free to contact me directly at (916) 469-3376 or edowdy@aging.org.

Sincerely,



Eric Dowdy, MPPA
Director of Policy

Dual Eligibles Demonstration Project RFS Draft

Comments submitted for the Department of Health Care Services' consideration by AIDS Healthcare Foundation

Page 3, Paragraph 2
One month is not sufficient time to develop a quality proposal for this project. DHCS should extend its turnaround time for RFS applications submission to two months.

Page 9, Paragraph 4
Many specialized HIV/AIDS providers are not in large healthcare plans' networks. Protections must be in place to guarantee patients have access to specialized HIV/AIDS care.

Page 10, Paragraph 3
AIDS Healthcare Foundation requests that the following language be added to the RFS: "In Demonstration areas where AIDS Healthcare Foundation's managed care plans are available, AHF's plan will remain a separate program. HIV positive dual eligibles meeting the eligibility requirements will be able to select AHF, the Demonstration plan, or may opt-out of both."

Page 12, Paragraph 5
DHCS needs to further explain the rationale for declining to use the Medicare star system for quality incentives.

Page 13, Paragraph 1
What entity will be developing the rates for the new capitated payment model?

Page 25, Paragraph 4
NCQA does not accredit Medicare SPN. Every nationally recognized accreditation agencies' accreditations should be considered equally. For example, DHCS should equally weigh accreditations from the Utilization Review Accreditation Commission (URAC), the Joint Commission and the Accreditation Association for Ambulatory Health Care (AAAHC).

Page 27, Paragraph 1
C-SNPs and Institutional SNPs have dual eligible patients within their structures and to exclude them is to deny them participating in the Demonstration Project. Therefore C-SNPs and Institutional SNPs must be included

January 9, 2012

Toby Douglas, Director
California Department of Health Care Services
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Delivered via e-mail to: OMCPRFP9@dhcs.ca.gov

Director Douglas,

We, the undersigned organizations representing HIV/AIDS service and care providers across the State, thank you for the opportunity to offer brief comment on the draft Request for Solutions (RFS) for California's Dual Eligibles Demonstration Project. The RFS stated that "DHCS is seeking comments on … whether the Demonstration should exclude beneficiaries with … HIV/AIDS…" We urge that this population not be excluded full stop from the demonstration. Instead, we urge that all beneficiaries be included on an opt-in basis and ask that people with HIV be included in the demonstration. We do, however, oppose any effort to passively enroll people with HIV into the demonstration, as this could easily lead to damaging disruptions in care.

HIV/AIDS is a treatable, chronic condition that necessitates ongoing care and treatment. Given the treatment options available today, it is now possible for people living with HIV/AIDS to have long, healthy lives. Ongoing care and treatment for people living with HIV and AIDS is also now known to be one of the most effective tools for preventing the further spread of this disease.

Relative to the general population in California, a disproportionate number of people living with HIV and AIDS accesses its care and treatment as dual eligibles. This beneficiary population requires continued access to appropriate primary and specialty care and treatment. HIV/AIDS is also a disease for which many patients have been receiving their care from physicians with whom they have built relationships and trust. While all patients would be given the opportunity to opt-out of participation in the demonstration projects, we are concerned that passive enrollment of people with HIV and AIDS could adversely impact patients' ongoing access to care and treatment, as well as their access to the specialists upon whom they have relied for care and treatment for many years.

We support the goals of a better-coordinated system of care for dual eligibles, and we hope that the end result for people living with HIV and AIDS is improved care and treatment leading to healthier, longer lives. We also ask that, for the purposes of this demonstration project and for the reasons stated above, that this beneficiary population be included through an active, opt in enrollment, rather than through a passive, opt out process.

Sincerely,

AIDS Project Los Angeles
Asian & Pacific Islander Wellness Center
Desert AIDS Project
Los Angeles Gay & Lesbian Center
Orange County HIV/AIDS Advocacy Team
Project Inform
San Francisco AIDS Foundation

Dear Colleagues at the DHCS,

I am pleased to provide comment on the Draft Request for Solutions (RFS) for California's Dual Eligibles Project. My comments apply to dual eligibles with Alzheimer's Disease or related dementias. Since these conditions are much more prevalent among an older population, I believe there will be a substantial number of duals in the demonstrations who will be struggling with cognitive impairment. Furthermore, since these are difficult clients to identify, diagnose, treat and manage, and since they are expensive patients in any health care system, I believe special attention needs to be paid to their care.

The State of California has developed an evidence-based practice guideline for Alzheimer's Disease Management. A one-page summary is attached. This guideline should help providers in the California demonstration and should be disseminated to all applicants. Please let me know if additional information is desired on this tool.

Here are specific comments on how to make the RFS more pertinent to the needs of people with dementia. I've done my best to be brief and to follow your suggested format.

Page 36 Section 2.2 IHSS -

To assure that people with dementia are identified, allotted appropriate in-home services, and cared for appropriately, it is necessary to add - "***Training for care coordinators and for care providers in the unique presentation and needs of people with dementia and Alzheimer's disease."*** Otherwise, history shows that these patients will be under-recognized, misunderstood, and cared for poorly.

Page 37 Coordination and Integration of Mental Health and Substance Use -

In a program for duals, there is not only a need for a dedicated psychiatrist but for a psychiatrist with training in ***geriatric psychiatry***. In California, people with Alzheimer's and most dementias are not cared for by County Mental Health systems. Their care has been "carved out." Therefore it is critical that the plans have geriatric psychiatry expertise to deal with the challenging behaviors seen in people with dementia such as hallucinations, delusions, paranoid ideation, agitation, insomnia, and so forth. These are the behaviors that frequently lead to expensive emergency room, hospitalization and nursing home use.

In the sentence, "Describe how you will include consumers on local advisory committees to oversee the care coordination . partnerships and progress toward integration", I would suggest that the wording be changed to state "***consumers or their advocates***." People with moderate to severe cognitive impairment will not be able to participate but their advocates (family caregivers or consumer advocacy groups like the Alzheimer's Association) can represent them.

Page 39 Section 5.1 Consumer Choice-

I recommend that you make the following edit in order to be responsive to the consumer choice for people with dementia who cannot independently represent themselves.
"Describe how beneficiaries ***or their surrogates such as family caregivers for people with moderate to severe dementia*** will be able to self-direct their care..."

Page 43 Section 8 Monitoring and Evaluation

Please consider adding a new bullet as follows:
Describe your organization's capacity for reporting beneficiary outcomes by cognitive status (specifically, no cognitive impairment vs. moderate to severe cognitive impairment).

People with moderate to severe cognitive impairment are drivers of cost for Medicare and Medicaid. They cost Medicare 3 times more than other beneficiaries (Bynum et al, JAGS, 2004 - see attached) . This is driven primarily by hospitalizations. They cost Medicaid 9 times more than other beneficiaries (Alzheimer's Association, 2009 AD Facts and Figures). This is driven by institutionalization. If we can measure outcomes for these beneficiaries, and if we can cut their hospitalizations and institutionalization, we can substantially save money.

Thank you for your invitation to provide comment. If you have any questions, please do not hesitate to contact me.

Sincerely,
Debra Cherry, Ph.D.
Executive Vice President
Alzheimer's Association, California Southland Chapter

e o

I SS Page 9 and Secti n : H S a es 23 d 2

Wi l d o st at si s e a o ed to ovi I S - p s rv s n c r e l a ai le ro g S i y on a o s r e i e ban assi anc , wat n pl ts c r g f r pe el a an n to o al ct v etc.

n al om n

e G vern r sed ro se 1 -2 3 u ge t a . he b dg e s oi i he pp s e i e io ual eli ibl (lo g rm a int gra ion) p oso h In tea of o er g mmu ity base r (S), t e G ver s p os ng ke de astati c ts o p og a l hes cu s a ea iz he th p a il h fa fe e l ar t ocu on c m n ty ba ca . I j t do ’t der an h G ve no th ki g

n er ly

Bu a es
9 76-6 6
al t sa l d o n y ca g

January 9, 2012

Toby Douglas
Director
Department of Health Care Services
Procurement Office
OMCPRFP9@dhcs.ca.gov VIA EMAIL
1501 Capitol Avenue
Sacramento, California 95899

Re: Request for Solutions for California's Dual Eligibles Demonstration Project

Dear Director Douglas:

Thank you for the opportunity to submit comments on the proposed site selection criteria for California's Dual Eligibles Demonstration Project (Demonstration). CalOptima supports the State's efforts to improve care coordination and delivery for duals. We commend the Department of Health Care Services (DHCS) for its leadership in pursuing innovative solutions to meet the health care needs of some of California's most vulnerable Medi-Cal members and look forward to continuing to work with the state and our local partners to better serve these members.

We offer comments and seek clarification on a number of provisions contained in the Request for Solutions (RFS) released by DHCS on December 22, 2011. The key areas that we would like to highlight for further discussion are:

1. Demonstration population
2. Scope and management of benefits
3. Rate development
4. Operation of Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs)

1. Demonstration population

In response to the questions posed by the DHCS in the RFS, CalOptima believes that our members would be best served if the Demonstration applied to the most inclusive population possible. High need and high risk members, such as those with HIV/AIDS or ESRD, are also those who may benefit most from a coordinated care approach. In the counties with County Organized Health System (COHS) plans such as CalOptima, all duals, including those members with HIV/AIDS and ESRD are enrolled in the plan for Medi-Cal services. Medicare Advantage plans can receive waivers to enroll ESRD patients. These are models of coordinated care for these high need members that can be improved with an integrated model.

2. Scope and management of benefits

CalOptima commends DHCS for the comprehensive benefit set envisioned for the Demonstration. While we understand and agree with the phased-in approach to the long term care support services, we are concerned that plans are being asked to assume financial risk for benefits such as In Home Supportive Services (IHSS) without the ability to actually manage them. For plans to be financially at risk for any benefit, they must assume administrative and/or utilization management responsibilities for that benefit. This is critical to the success of this Demonstration. We look forward to working closely with DHCS and other stakeholders to develop an appropriate approach to phasing in these responsibilities in a way that will ensure continued and quality care for duals.

As we develop our response to the forthcoming RFS, we request clarification on the following issues:

As part of the proposed FY 2013 state budget, the State intends to transition long term care (LTC) support services, including IHSS, to Medi-Cal managed care. As the only Medi-Cal provider in their counties, COHS will be responsible for LTC support services for all Medi-Cal members, including those duals participating in the pilots and those that opt out.

- Will COHS be required to offer a distinct Medi-Cal product for participants in the Demonstration?
- Will this include unique member identification and enrollment processes?

Another key component of the Demonstration, as discussed in the RFS, is the provision of supplemental services. The State clearly recognizes the importance of permitting pilot sites the flexibility to offer services that will best meet the needs of its participants. Flexibility in the provision and administration of benefits will be an important component of the Demonstration. We request that the State ensure that pilot sites are afforded the necessary flexibility to work with local stakeholders and, with local support, develop administrative and/or contracting arrangements that will best meet the needs of that community and its providers. Examples of where this flexibility will be critical include; the IHSS program, MSSP, assisted living, and the provision of behavioral health services and services provided in institutions for mental disease (IMDs).

3. Rate development

We recognize that the rate development process is in its early stages and DHCS has many important variables to consider. We look forward to working closely with you and your staff to support these efforts and respectfully request that DHCS continue to maintain an open and transparent rate development process.

As stated by DHCS in the RFS, duals are among the highest need users of health care services. Given Medi-Cal managed care plans lack of clinical experience with these beneficiaries, particularly for Medicare services, additional data from the Centers for Medicare & Medicaid Services (CMS) and the State will be critical to developing an informed response to the RFS.

We appreciate DHCS' willingness to work with potential applicants seeking additional Medicare and Medi-Cal data.

As we develop our response to the forthcoming RFS, we request clarification on the following issues:

Rate setting

- How will be IHSS and/or BH be reflected in the integrated rates? Is the State proposing a phased-in approach?
- Will the LTC facility payment be integrated into the blended capitation rate or remain as a pass-through payment?
- How will the provision of supplemental benefits be reflected in the integrated capitation rate?
- How does the State plan to calculate anticipated savings: using reduced administrative and/or medical expenses?

We reiterate the importance of ensuring that pilot sites not be at financial risk for benefits over which they have no administrative responsibility. We recommend that payments for these services be structured as pass-through payments until plans assume some level of administrative responsibility.

Risk adjustment

Recognizing Medi-Cal managed care's limited experience providing comprehensive services to duals, we strongly encourage the State to develop a risk adjustment approach that mirrors Medicare's hierarchical condition categories (HCC) risk adjustment model or the Program of All Inclusive Care for the Elderly (PACE) risk adjustment model. This will account for the unique and complex needs of this population and ensure that pilot sites are able to gain needed clinical experience to improve care management.

Additionally, we understand that there are many outstanding questions related to how currently institutionalized beneficiaries will be integrated into the Demonstration. CalOptima recognizes the importance of having a care transition plan available for those members that are able and willing to transfer back into the community; however, we do not believe that it is feasible for the State to anticipate any savings from these care transitions until we have established a baseline of experience.

Risk protection

For reasons identified above, participating plans will need risk protection in the early years of the Demonstration. We encourage the State to provide risk protection to participating plans through risk corridors.

We believe that, particularly in the early years of the Demonstration, savings should not be assumed until the pilot site has gained adequate experience to project savings. Maintaining current funding levels and permitting plans to reinvest savings into the program will establish a clear baseline for future rate setting and allow both the State and plans to realize long term savings.

- What opportunities for shared savings are there for potential pilot sites?
- Would the State be willing to consider an approach where savings are anticipated and actual savings are shared at the end of the demonstration year rather than from the outset?

4. Operation of D-SNPs

Under a passive enrollment model, all duals will be enrolled with the pilot site. This model raises many questions for the D-SNPs operated by the pilot sites and the other D-SNPs competing in the same geographic area.

As we develop our response to the forthcoming RFS, we request clarification on the following issues:

- Will D-SNPs continue to be operational in the pilot counties? Will participating duals be rolled into the pilot site's D-SNP?
- Will the enrollees of the D-SNP be rolled into the Demonstration?
- If CMS/DHCS intends to enroll all duals into the Demonstration in a pilot county, what will be the process to phase out the D-SNPs operating in that county? When will those SNPs receive notice? What will the impact be on those D-SNPs that have already submitted bids for 2013?
- Will CMS/DHCS consider excluding duals currently enrolled in a SNP from the passive enrollment process?

We respectfully request that DHCS consider a phase-out of D-SNPs in pilot counties. This approach will allow for continuity of care and a smooth transition into the new integrated service delivery model for duals. We propose that in Phase I of the Demonstration, all current SNPs will be maintained with the pilot site coordinating care in connection with these SNPs. In Phase 2, we would propose a gradual "rolling in" of D-SNP members into the pilot, using a collaborative stakeholder process to establish criteria for how duals will be transitioned.

Additionally, DHCS has proposed an aggressive timeline for National Committee for Quality Assurance (NCQA) accreditation by pilot sites. While we support the State's effort to ensure the highest quality of care and are in the process of achieving NCQA accreditation, we recommend that the State consider allowing plans that have met the strict quality requirements of becoming a D-SNP to be given additional time to secure NQCA accreditation.

Again, thank you for the opportunity to offer comments on the proposed site selection criteria for California's Dual Eligibles Demonstration Project. We look forward to a continued partnership with you and your staff as this process moves forward and we work to provide the best possible care to our dual eligible beneficiaries.

Sincerely,

Richard Chambers
Chief Executive Officer

RC

1120 West La Veta Avenue | Orange, CA 92868 | www.caloptima.org
Main: 714. 246. 8400 | Fax: 714. 246. 8492 | TDD: 714. 246. 8523

California Assisted Living
CALA
Association

455 Capitol Mall
Suite 222
Sacramento
California
95814

(916) 448-1900
Fax: (916) 448-1659

January 6, 2012

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue, MS 0000
PO Box 997413
Sacramento, CA 95899-7413

RE: Comments on draft Request for Solutions for California's Dual Eligibles Demonstration Project

Dear Mr. Douglas:

The California Assisted Living Association (CALA) is concerned that the draft Request for Solutions for California's Dual Eligibles Demonstration Project inappropriately classifies RCFEs as "institutions" and directs the project to move residents out of this setting. This is a direct contradiction to demonstrated consumer choice and the reality of this popular care model.

Residential Care Facilities for the Elderly (RCFEs), also referred to as Assisted Living communities, are by definition and design a residential setting where seniors receive assistance with activities of daily living and have access to a wide variety of social and health related support services. Whether living in a converted single family home or a larger apartment style community, Assisted Living consumers certainly do not believe that they are living in an institution. Consumers choose Assisted Living and have made it a successful and popular option because of its residential environment, person-centered philosophy, and flexibility in responding to changing needs and preferences.

For these reasons, we strongly urge the department to remove RCFEs from the examples of "institutions." Thank you for the opportunity to comment and engage in the effort to design this program. If you would like to talk about our concern in more detail, please call me at 916-448-1900.

Sincerely,

Heather Harrison
Vice President of Public Policy

The Voice of Assisted Living

cc: Erin Levi, Lehman Levi Pappas & Sadler

californiapharmacistsassociation

January 9, 2012
DHCS Office of Procurement
OMCPRFP9@dhcs.ca.gov

RE: Comment on California's Dual Eligible Demonstration Request for Solutions
California Department of Health Care Services DRAFT Released: December 22, 2011

Under "Pharmacy benefits" it is stated that: *Demonstration Sites will be paid according to the regular Part D payment rules, with the exception that they will not have to submit a bid. The direct subsidy will be based on a standardized national Part D average bid amount. This national average will be risk adjusted according to the same rules that apply for all other Part D plans. CMS will provide additional guidance for plans in the Draft and Final Call letter for contract year (CY) 2013 in February and April 2012, respectively.*

I am unclear as to where DHCS would be acquiring the figures for the national average, and is there an adjustment for the benchmark plans that might be substantially different? Additionally, when folding the nursing facility patients into the demonstration project, is DHCS taking into account that with Part D the LTC pharmacies are reimbursed at a higher rate than the community pharmacies because of the specialized packaging for LTC patients, as well as the requirement to be available 24 hours in the event an emergent or urgent event occurs and a patient requires a stat order. It would be most helpful to understand how the benefit will be detailed prior to the Final Call Letter for the contract years.

I appreciate any clarity you might have on the above comments.

Sincerely,

R. Paige Talley
Executive Director
Long Term Care Management Council

4030 Lennane Drive, Sacramento, CA 95834 Voice 916-779-1400 Fax 916-779-1401

CALIFORNIA ASSOCIATION OF AREA AGENCIES ON AGING

Live Well…Live Long

January 9, 2012

Toby Douglas, Director
California Department of Health Care Services
1501 Capitol Mall
P.O. Box 997413
Sacramento, CA 95899-7413

RE: Dual Eligible Demonstration Draft Request for Solutions

Dear Mr. Douglas:

The California Association of Area Agencies on Aging (C4A) has been very interested and supportive of the development of demonstration projects to better coordinate the care and services for persons eligible for both Medi-Cal and Medicare. We have actively followed the legislative and stakeholder process and welcome this additional opportunity to provide input.

C4A appreciates the department's steps to seek the views of stakeholders in designing these demonstrations and most recently your efforts to seek comments on the Request for Solutions (RFS). The RFS has been most helpful in understanding the thinking of DHCS, the direction the department wants to take the project, and who the department considers primary stakeholders.

It is the latter that C4A is most disappointed; the near absence of a defining role for area agencies on aging and the apparent lack of understanding of the part that area agencies play in the local home and community-based services network. Area agencies on aging bring to the table a comprehensive approach to services, an understanding of the broader long-term care system and are the focal point in the community regarding outreach, education, as well as information and assistance.

From the perspective of area agencies on aging, C4A offers the following comments on issues we believe the State should consider in not only finalizing the draft Request for Solutions, but also in evaluating the responses to the RFS and negotiating with the selected sites.

Stakeholder Involvement and County Support
The RFS requires applicants to submit letters of agreement from County officials with operational responsibility fro IHSS and aging services. We are alarmed at the lack of understanding that only one-half of the area agencies on aging are based in a county. Many of the area agencies are non profit or organized through joint power agreements. These area agencies would be excluded from playing any role in providing support for applicants and developing a potential partnership.

Likewise, the provisions regarding stakeholder involvement is silent about the role of area agencies on aging have in the process regarding the dev4elopment, implementation, and continued operation of the project. A successful demonstration will depend on all the various stakeholders, including those responsible for social and aging services.

The stakeholder process must include all area agencies on aging.

Social Support Coordination
Area agencies on aging are essentially ignored as having a role in keeping individuals out of nursing homes and living in their own community. The RFS requires applicants to describe how they will assess and assist beneficiaries in connecting to community social support programs that support living in the home and community. Although the document specifically identifies Aging and Disability Resource Centers (ADRC) it fails to refer to area agencies on aging. C4A believes this is a major oversight, especially in light of there being only a few ADRCs throughout California and there is an area agency in every county.

Long-Term Services and Supports
C4A is believes in a much broader definition of long-term services and supports. Home and community-based services are more than IHSS, CBAS, and the waivered programs. Area agencies fund services such as personal care, homemaker, chore, adult day care, congregate nutrition, home delivered meals, transportation, home modification, case management, information and assistance, and outreach and education. Health Insurance Counseling and Advocacy Program (HICAP), an integral program in the local service network, will be dramatically impacted when the enrollment process begins. The RFS needs to focus more on the impact to the local HICAP provider in explaining the process and benefit package to beneficiaries in a way they can understand. It must be recognized and understood that area agencies are mandated by federal law to coordinate and plan services for older persons. Consequently, C4A believes that the RFS must identify and provide for a range of social services that are provided by area agencies in the local community.

Area agencies on aging are prepared to be part of the process in designing an approach that responds to Californian's dual eligible beneficiaries.

Sincerely,

Derrell Kelch
C4A Executive Director

980 Ninth Street, Suite 240 ✦ Sacramento, CA 95814 ✦ Phone (916)443-2800 Fax (916)554-0111
Email: aging@c4a.info ✦ Website: www. c4a.info

CALIFORNIA
ASSOCIATION OF
HEALTH FACILITIES

CAHF

Supporting People, Health and Quality of Life

January 9, 2012

DHCS Procurement Office

Email: omcprfp9@dhcs.ca.gov

Main Office:
2201 K Street
Sacramento, CA
95816-4922
(916) 441-6400
(916) 441-6441 fax

Southern California
Regional Office:
560 N. Coast Hwy 101
Suite 8
Encinitas, CA 92024

P.O. Box 370
La Jolla, CA
92038

(760) 944-1666
(760) 944-1049 fax

www.cahf.org

Subject: Request for Solutions (RFS) California's Dual Eligibles Demonstration Project

This is in response to Toby Douglas' December 22, 2011, request for comments on the above.

The California Association of Health Facilities (CAHF) is a non-profit professional association founded in 1950 to serve as a statewide organization for long-term care providers. CAHF's membership is comprised of more than 1,300 licensed non-profit and proprietary long-term care facilities serving a wide spectrum of needs in settings which include skilled nursing, intermediate care, subacute, mental health, and services for persons with developmental disabilities. Nearly 100,000 trained medical professional and support service staff care for 300,000 Californians in these facilities each year.

California currently has 3.5 million people over the age of 65—the largest older adult population in the nation. This number is expected to increase to more than 6 million by 2020. The greatest growth will be among the age cohort most reliant on nursing facility services—the elderly population aged 85 years and older. Our members play a leading role in the continuum of care that has evolved to meet the short- and long-term medical needs of this population. Medi-Cal and Medicare comprise 80 percent of the revenue for skilled nursing facilities, and Medi-Cal funds almost 100 percent of the care for people with developmental disabilities that reside in institutions.

Purpose and Background (Pages 3 and 5): As stated in prior correspondence, CAHF is concerned that the RFS continues to focus on the goal to "rebalance the current health care system away from avoidable institutionalized services and toward enhanced provision of home- and community-based services" without recognizing that California is a national leader in this area. The 2012-13 Budget provides for an estimated savings of $678.8 million in 2012-13 for enrollment of duals into managed care. Please arrange for a meeting with CAHF and DHCS staff to discuss the assumptions for the budget savings and the proposed methodology for capitated rates.

Demonstration Population and Section 2.1 LTSS Capacity (Pages 7 and 23): The RFS proposes that demonstration sites will be responsible for the provision of all medical and long-term support and serviced for enrolled developmentally disabled (DD) beneficiaries. When DHCS implemented the mandatory enrollment of seniors and disabled persons, DHCS specifically excluded DD clients who resided in long-

term care facilities from mandatory enrollment. We suggest that the same policy be implemented for the demonstration sites. DD clients receive case management services from Regional Centers, which are responsible for living arrangements that meet the medical and social needs of the clients. Requiring these disabled beneficiaries to be assigned to a managed care plan would be duplicative of the services provided by the Regional Centers and not in the best interest of this group of beneficiaries. Page 23 inappropriately asks for Applicants to provide a transition plan to move individuals out of intermediate care facilities for the developmentally disabled (ICFs/DD). There are approximately 1,200 ICFs/DD in California. They are small residential homes that are integrated into neighborhoods and generally care for six patients. Many DD clients have resided in their home for 10 to 20 years. To propose removing these clients from their homes is unconscionable. DHCS must reconsider this provision and should exclude DD clients from this RFS.

Demonstration Population (Page 7): CAHF supports the exclusion of individuals who have been institutionalized for longer than 90 days. If a demonstration site cannot arrange for home- and community-based services within the first 90 days of institutionalization, it is doubtful that they will be successful given more time. The RFS must recognize that long-stay chronic care may be medically necessary when the consumer may prefer to receive services in a facility setting and/or may not be safely cared for in the community. In addition, disenrollment from the demonstration site will provide operational efficiencies for the nursing facility by removing the complication of dealing with a third bureaucracy (the demonstration site) when the services for the balance of patients in the facility are authorized and paid by Medi-Cal fee-for-service and/or Medicare. The RFS should be modified to clarify that individuals excluded for mandatory enrollment have the option to voluntarily enroll in the managed care plan.

DHCS has not explained the rationale for excluding patients with HIV/AIDS, end-stage renal disease and amyotropic lateral sclerosis from mandatory enrollment. If the demonstration does not exclude beneficiaries who have been institutionalized for longer than 90 days, the list should be expanded to include other medically fragile populations such as Alzheimer's disease, severe dementia, Huntington's disease, other progressive degenerative neurological conditions, beneficiaries enrolled in hospice, hepatic system failures, and persons requiring ventilator services. The RFS should be modified to clarify that exclusion of these individuals from mandatory enrollment does not prevent them from voluntarily enrolling in the managed care plan.

Enrollment (Page 7): The RFS allows demonstration sites to choose a passive enrollment process for both Medicare and Medi-Cal, with opt-out provisions. There should be a process to allow a beneficiary to prevent enrollment in a demonstration site to avoid disruption in services and to assure continuity of care provided by a Medicare provider that is not part of the Applicant's network. CAHF does not support a "lock-in" for up to six months because it removes the freedom of Medicare beneficiaries to choose their health care provider. A lock-in would disrupt their health care by forcing them to see new providers when many of the elderly and disabled have been seen by the same physicians, including specialists, for years.

Benefits (Page 8): The RFS provides that the demonstration site shall be responsible for providing enrollees access to the full range of services currently covered by Medicare Parts C and D and Medi-

Cal State Plan benefits. This statement should be modified to include Medicare Part A and Medicare Part B benefits. As written, it appears that the RFS does not require demonstration sites to provide Medicare Part A skilled nursing services. Currently, Medicare Part A pays for post-acute care, after a three-day qualifying hospital stay, in a skilled nursing facility that will allow the patient to heal and return to home. The RFS should clearly identify that short-term post-acute care, which includes medically complex services (IV therapy, etc.) and rehabilitation therapy services are to be covered by the demonstration site. Short-term patients require rehabilitative services following surgery, such as a hip or knee replacement, or comprehensive care to recover from cardiac, pulmonary and neurological conditions before returning home. Skilled nursing facilities have become the dominate provider of these types of post-acute services in the Medicare program.

The RFS must recognize that skilled nursing facilities play a critical role in the delivery of short term post-acute care and are more efficient at a lesser cost. These facilities reduce the cost to care for patients who would otherwise continue their care in the general acute care setting. Skilled nursing facility care enables consumers to have better outcomes so that they can return to independent living in their home. Without aggressive rehabilitative services or comprehensive care that is necessary to improve a consumer's health status, costs for acute care stays and expensive re-hospitalizations may increase significantly. The Applicant and DHCS must recognize the potential for savings that can be realized by no longer requiring a three-day acute care stay prior to authorization of Medicare Part A skilled nursing services. The applicant has the flexibility under the dual pilot to admit patients directly to the skilled nursing facility for treatment that does not warrant the expense of an acute care stay. For example, a beneficiary may require care for a pressure ulcer or a urinary tract infection that was acquired at home. Instead of authorizing acute hospital care, the Applicant can authorize treatment in a skilled nursing facility at a much lower cost. This is a critical component of the health care continuum and should not be overlooked, since the Medi-Cal program alone fails to provide significant therapy services.

LTSS Capacity (Page 23): Applicants are asked to describe their experience dealing with group homes, residential care facilities for the elderly (RCFE), intermediate care facilities (DD and BH), congregate living facilities and other type of "institutionalized" settings. Applicants are asked to describe a transition plan for moving individuals out of these care settings.

As previously stated, the misguided proposal that Applicants should transition DD beneficiaries out of ICFs/DD should be removed from the RFS. CAHF also objects the expectation that the Applicant will transition behavioral health (BH) beneficiaries from residential and inpatient settings. BH beneficiaries may appropriately reside in skilled nursing facilities with special treatment programs for the mentally disordered [SNF/STP or Institutions for Mental Disease (IMD)], mental health rehabilitation centers (MHRC), psychiatric health facilities (PHFs), adult residential facilities (ARFs), or residential care facilities for the elderly (RCFEs). BH clients in who reside in SNFs/STP and MHRCs have been conserved by the court and ordered to receive involuntary care in a locked/secured setting. Decisions about their care are made by their conservator and the county. Furthermore, the counties, not the Applicant, will be the primary source of funding, with county case managers coordinating and managing client services. Case managers approve lengths of stay, decide when a client is ready for discharge to a lower level of care, or can benefit from less restrictive

community-based services. Since BH clients care is already coordinated with conservators and managed by county case managers, there is little benefit for them to be enrolled in pilots. However, in responding to RFS, Applicants should be aware of the unique nexus between the counties and public guardian's office for this population of dual eligibles. We continue to suggest that DHCS carve them out of the demonstration, or DHCS should be very specific on how it expects the Applicant to successfully integrate this population into pilot.

CAHF was surprised by the inclusion of RCFEs as "institutionalized" care in the RFS (Page 23). According to Department of Social Services, there are over 8,000 RCFEs in California. These assisted living facilities allow the elderly to stay in a home-like environment when they cannot stay in their own homes because of their inability to perform activities of daily living and do not have extensive medical needs. DHCS should request that Applicants explain their plans to provide medical case management for RCFE residents who have chronic care needs to reduce emergency room visits and hospitalizations, instead of transitioning the elderly clients to other living arrangements.

Integrated Financing (Page 4)

CAHF recognizes that the financing model is still a work in progress and details are yet to be clearly defined. However, CAHF has a general concern and wants to emphasize the critical importance that capitation rates set under the new capitation model are sufficient to sustain the Applicant's network and required range of services without compromising quality. This includes the level of capitation identified to the delivery of post-acute and long-term care services. DHCS must recognize that Medicare Part A RUGs rates and Medi-Cal AB 1629 rates should be considered as the rate floor when establishing capitation for post-acute and long-term care services provided by free-standing skilled nursing facilities.

We look forward to meeting with DHCS about the fiscal assumptions relating to the RFS and the proposed budget savings. If you have any questions, please contact Nancy Hayward, Assistant Director of Reimbursement, at (916) 441-6400, ext. 106.

Sincerely,

James H. Gomez
CEO/President

California Association of Health Insuring Organizations

CAHIO

January 9, 2012

Toby Douglas, Director
California Department of Health Care Services
P.O. Box 997413, MS: 0000
Sacramento, CA 95899-7413

RE: Comments on draft Request for Solutions (RFS) for California's Dual Eligibles Demonstration Project

Dear Mr. Douglas:

On behalf of the California Association of Health Insuring Organizations ("CAHIO"), which represents the six (6) County Organized Health Systems ("COHS") that provide services to nearly 1,000,000 Medi-Cal beneficiaries, approximately 172,000 of whom are eligible for both the Medicare and Medi-Cal program, I'm writing to provide comments on the draft "Request for Solutions (RFS) for California's Dual Eligibles Demonstration Project." CAHIO appreciates the opportunity to comment on the RFS and thanks the Department of Health Care Services (DHCS) for its efforts to ensure that stakeholder comments are considered in the design of the demonstration project.

First, CAHIO wants to express its support of DHCS' goal of improving care to dual eligible beneficiaries through an integrated, coordinated delivery system. CAHIO strongly believes that through integration, improved outcomes for the most medically vulnerable beneficiaries, increased satisfaction and participation of providers and savings opportunities can be achieved.

In addition to offering its support for the concept of integration of services for dual eligible members, CAHIO also would like to provide comment on the draft RFS language regarding integrated financing, which proposes rates of payment to be developed using baseline spending in both programs. CAHIO is concerned that using baseline Medicare payments in certain geographic areas which already include unfairly low physician payment rates may have the unintended affect of creating a barrier to successful implementation in certain counties.

Unlike Medi-Cal, which includes physician rates of payments that are consistent across counties, Medicare physician payments are based on an antiquated system developed in the mid-1960's which classifies certain counties as rural for the purposes of determining

physician Medicare payment rates, including COHS counties of Monterey, Marin, Santa Cruz, Merced, San Luis Obispo, Santa Barbara and Sonoma.

These low rates of payment already impact access in certain counties where physicians' practice and living costs have risen substantially since the mid-1960's, and so many physicians are no longer are willing to accept new Medicare patients. Accordingly, CAHIO urges DHCS to consider the impact of these inappropriately low rates on the feasibility of developing an integrated system of care if not addressed in the rate development process. CAHIO suggests DHCS may be able to resolve this issue and support the development of dual integration programs in these counties by adjusting the expected savings target in affected counties.

Finally, as a point of clarification, CAHIO would like to confirm that COHS plans would not need to seek separate Medi-Cal Knox-Keene licensure for purposes of participating in the demonstration. As you know, COHS plans are exempt from Knox-Keene licensure for Medi-Cal pursuant to Welfare and Institutions Code Section 14087.95. COHS plans comply with all Knox-Keene standards via the contract with DHCS and operate under licenses for all other programs such as Healthy Families Program and Medicare Advantage.

CAHIO looks forward to working with DHCS on developing integrated, coordinated systems of care in it COHS counties and would appreciate the opportunity for a more in depth discussion with DHCS in order to solve the issue of inequitable Medicare physician payments in certain rural designated counties.

Sincerely,

Robert S. Freeman
Chair, CAHIO

cc: CAHIO plans
Jane Ogle, Deputy Director, DHCS

Comments on
California's Dual Eligible Demonstration Request for Solutions
California Department of Health Care Services
DRAFT Released: December 22, 2011

It is stated in Appendix F **Framework for Understanding Mental Health and Substance Use:**

California's dual eligible population includes many individuals who need mental health services.
This includes people with short-term needs and those with chronic needs who qualify for Medicare and Medi-Cal due to a psychiatric disability. Substance abuse frequently co-occurs
among these individuals. Patient-centered, coordinated care models should address the full continuum of services beneficiaries need, including medical care, mental illness and substance
use services in a seamlessly coordinated manner.

Both in this appendix and elsewhere in describing requirements for benefits, network adequacy and care coordination there should be a reference to the model for care for those with psychiatric disabilities which is set forth in the Welfare and Institutions Code Adult System of Care (section 5800 and following sections especially section 5806.) Applicants must assure continuity of care through the same providers and those models of care for those currently served and include providers with that experience and that model within their networks either directly or through their contract with county mental health which currently funds these programs. Moreover, contracts must be written to integrate all of the funding for those programs which include non medical supportive services necessary for recovery from a severe mental illness. These services, which are not eligible for MediCal or Medicare reimbursement, are funded through county mental health either directly operated or through a contract that also includes the MediCal reimbursable services. The MOU with county mental health must include the means to include that funding and those services.

Submitted by

Rusty Selix
Executive Director
California Council of Community Mental Health Agencies

January 6, 2012

Peter Harbage
Harbage Consulting

Via email: info@calduals.org

RE: Duals Integration Demonstrations – Comments on Duals Demonstration Background and Process Overview by the California Elder Justice Workgroup

The California Elder Justice Workgroup (CEJW) is pleased to provide comments on the California Duals Demonstration working paper. CEJW was formed in 2008 to protect the rights, independence, security, and well-being of vulnerable older adults in California by improving the response of the legal, protective services, and long-term care systems. Our goal is to provide a unified voice for elder justice advocates in California, identify unmet needs for services and policy, and offer promising solutions.

CEJW fully agrees that the process of developing California's duals demonstration criteria should be more than a listening process but rather, an open dialogue between the state and stakeholders that informs the ultimate design. We believe however that one critical voice has been missing: agencies and individuals that form California's safety net for older adults and adults with disabilities. This includes adult protective services providers (APS), long-term care ombudsmen, providers of legal aide, law enforcement, elder forensics centers, probate and elder court personnel, multidisciplinary teams, public guardians, and professionals and advocates in the fields of elder abuse prevention. These entities are routinely called upon when vulnerable older adults and adults with disabilities experience physical and emotional injuries, financial losses, physical decline, unnecessary institutionalization, and infringements upon their rights and independence as the result of abuse, neglect, or exploitation. Vulnerability to abuse, neglect, and self-neglect is heightened when older adults lack adequate and effective services and support.

CEJW further wholly supports the dual demonstration project's emphasis on empowering consumers to direct their own care—in fact, ensuring client autonomy and self-determination are among the principles that guide practice in our field. We believe however, that empowering consumers carries with it responsibility for protecting personal choice, economic security, physical safety, and civil liberties; and responding quickly when abuses occur.

Recent studies suggest that:

- One in 9 seniors has being abused, neglected or exploited in the past 12 months:
- 47% of caregivers have engaged in physical and psychological elder abuse and neglect;
- 2 million older adults had their identities used by younger family members, mostly adult offspring, for fraudulent reasons between 2006 and 2010;
- Elder abuse victims are 4 times more likely to go into nursing homes; and

- Almost one in 10 financial abuse victims will turn to Medicaid as a direct result of their own monies being stolen from them.

CEJW further believes that the dual eligible demonstration program provides an unprecedented opportunity to build critical safeguards into the foundation of California's LTSS system. We welcome the opportunity to raise our concerns about impediments to choice and the risks that LTSS consumers face, as well as offer recommendation. Our comments are directed toward the criteria spelled out in the "Framework for Understanding Long-Term Care Coordination in California's Duals Demonstration.

Impediments to Consumer Choice in the LTSS Market
Consumer choice in the LTSS marketplace depends on four requirements:
1. LTSS consumers must be capable of exercising choice and informed consent; those that lack capacity must have trustworthy decision-makers to act on their behalf;
2. Consumers must have information and assistance to help them exercise choice. This includes information about the quality of services, the qualifications and backgrounds of service providers, and assistance in evaluating services and workers;
3. Consumers need an adequate supply of qualified, trustworthy, and trained service providers from which to choose; and
4. The State and local communities must provide adequate oversight and consumer protections, and respond quickly to problems and abuses.

1. Capacity and Informed Consent
The ability to exercise informed consent may be compromised by mental and physical illness, diminished mental capacity, and undue influence. These factors may interfere with consumers' ability to evaluate the suitability of services and providers, assess risks, detect abuse, supervise workers, terminate abusive or negligent caregivers, or even seek help.

Currently, there are no agreed upon standards or guidance in determining when LTSS consumers in California are capable of exercising choice in the LTSS market. This determination can be extremely complex, particularly in light of emerging evidence about the impact of subtle deficits on judgment and decision-making. For example, in 2011 the Alzheimer's Association and the National Institute of Neurological Disorders and Stroke updated their criteria and guidelines for diagnosing Alzheimer's disease. The new guidelines reflect an emerging consensus that everyone who eventually develops Alzheimer's experiences a period of minimal impairment preceding full onset of the disease. Further, some experts believe that this "preclinical" mild cognitive impairment (MCI) is an important risk factor in elder abuse, neglect, self-neglect, and exploitation. The extent to which MCI affects consumers' ability to make informed choices and decisions remains unclear. Clearly those who work with LTSS clients need training and guidance to help them assess LTSS consumers' ability to exercise choice.

2. Training and Information to Facilitate Choice
The recently released *Raising Expectations State Scorecard Report*, a comparative analysis of states' LTSS systems produced by AARP, the Commonwealth Fund, and The

SCAN Foundation, ranked California 45th among the 50 states and the District of Columbia in "providing tools and programs to facilitate consumer choice." The extreme vulnerability of the LTSS population, the extended periods of unsupervised time clients may spend alone with workers, and recent revelations that a significant number of personal workers have been found to have criminal records, suggest the need for greater access to information about potential employees' criminal histories, work experience, and past histories of abuse, as well as other problems that may impact their ability to provide care. A primary area of need is for information and guidance to help LTSS providers and consumers screen workers and report problems. This includes information about when background checks are warranted, the types of background information that is relevant and available; and determining when service providers pose unacceptable risks.

3: Qualified Workers

LTSS consumers must have access to affordable, trustworthy, and well-trained workers. Although CEJW recognizes that the overwhelming majority of LTSS and IHSS workers provide high levels of care, the supply of screened and trained workers in California is inadequate to meet the need. To a great extent, this shortage is attributed to the fact that reimbursements are so low that even full-time workers do not earn a living wage and further lack basic protections and rights. The *Raising Expectations State Scorecard Report* ranked California 42nd among the states on the "availability of home health and personal care aides for older Californians." Elder justice advocates recognize that consumer choice with inadequate choices or help in choosing can be a dangerous combination.

4. Response to Abuse

Empowering vulnerable people to live in the community carries with it the responsibility for ensuring protection against unscrupulous, opportunistic, and predatory individuals. At present, California's system for keeping dangerous individuals out of the LTSS worker pool is vastly inadequate, as evidenced by a 2010 investigation by SACRAMENTO KABC-TV, which revealed that nearly 1,000 convicted felons were identified as either seeking jobs or working in California's In-Home Support Service program during the previous year.

Empowering LTSS consumers further carries with it the responsibility for providing a timely and effective response when problems or abuses occur. The need for emergency services and legal remedies to respond to situations in which persons who are unable to act in their own behalf are in grave, immediate danger are particularly critical. Dramatic cuts to critical safety net services, including APS, public guardians, mental health services, law enforcement, and legal assistance has compromised the safety net, and the "realignment" of some of these services has created additional uncertainties about local communities' capacity to respond when problems arise.

Even after serious abuse has occurred, those designated to respond are often unable to ensure that abusive workers are terminated and prevented from endangering others. A 2010 report by the California Senate Office of Oversight and Outcomes revealed that the lack of cross-reporting among licensing and regulatory agencies enable abusive workers

to move from one system of care to another. State and local entities need to work together to establish protocols and procedures for keeping dangerous persons out of the LTSS workforce.

Recommendations
CEJW recommends that the following safeguards be implemented by plans and the state entities that oversee them.

Plans selected to participate must demonstrate that adequate safeguards are in place. This includes:

- Screening of clients that reflects current understanding of risk factors associated with elder and dependent adult abuse, self-neglect, and diminished mental capacity and its impact on decision-making;
- Screening of LTSS workers that is informed by state-of-the-art research and knowledge about risk factors associated with abusers;
- Protocols for reporting elder and dependent adult abuse and neglect that include provisions for data sharing and care coordination;
- Partnerships and linkages with elder justice agencies, including APS, Ombudsmen, elder abuse prevention multidisciplinary teams and forensics centers, mental health service providers, discharge planners;
- Inventories of local elder justice resources; and
- Training to LTSS providers in elder abuse, elder justice, and workers' duty to report abuse.

State entities that oversee LTSS demonstrations must:

- Develop information and training for LTSS providers and consumers that reflect current understanding of vulnerability and risk, mild cognitive impairment, legal standards of decision-making capacity, and caregiver abuse. Also needed is information about strategies for reducing vulnerability, including instruction in how to draft "safe" advance directives for health care and finances, and techniques for mediating or preventing conflicts that pose a threat to caregiving systems;
- Clarify the steps that APS, Ombudsman, law enforcement and concerned parties can take to discharge abusive IHSS workers whose clients are incapable of doing so as a result of incapacity, coercion, or undue influence, and prevent them from securing employment with others. Criteria and procedures should also be developed to override clients' choices when failure to do so poses an unacceptable risk to the person, to others, or to the integrity of the LTSS system.
- Develop information systems to "red flag" abusers (those whose abusive actions have been substantiated by protective service, oversight, or law enforcement entities) and prevent them from gaining employment that endangers others.

Again, CEJW welcomes the opportunity to offer our recommendations. We would further welcome the opportunity to work with dual eligible demonstration personnel to ensure the safety and security of LTSS consumers. Please do not hesitate to contact us at WISE & Healthy Aging ([310] 394-9871, http://www.wiseandhealthyaging.org if we can be of assistance.

CALIFORNIA HEALTH ADVOCATES
Medicare: Policy, Advocacy and Education

January 9, 2012

Mr. Toby Douglas
Director, Department of Health Care Services
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Douglas:

Thank you for the opportunity to comment on the draft Request for Solutions (RFS) for California's Dual Eligibles Demonstration Project. We take this opportunity to comment, believing that our collaborative efforts will result in a new model or models that will provide better health care that improves the health of the dually eligible population and at the same time lower costs.

The mission of California Health Advocates (CHA) is to provide quality Medicare and related health care coverage information, education and policy advocacy. We are an independent not-for-profit organization that started as the California HICAP Association, and we continue to serve as an association for local Health Insurance Counseling & Advocacy Programs (HICAP). CHA provides accurate and up-to-date Medicare information through its website, www.cahealthadvocates.org, fact sheets, workshops, webinars and its network of local Health Insurance Counseling & Advocacy Programs and other community-based organizations. Our HICAP members provide Medicare benefits counseling and community education and outreach.

Comments on the draft RFS:

- Page 9, Enrollment

We support the goal to preserve and enhance the ability for consumers to self-direct their care and receive high quality care (p.8). Hence we disagree with allowing sites to choose a passive enrollment process or pursue an enrollment lock-in up to 6 months since both those options contradict the goal of enhancing self-directed care.

During the meeting on December 12, 2011 in San Francisco, someone expressed the concern that if voluntary enrollment was allowed, no one would enroll. We believe that a well-designed plan that advances the demonstration goals, if presented appropriately to the dually eligible

population, would attract many to enroll. An example of a successful model that uses voluntary enrollment is the Program for All-Inclusive Care for the Elderly (PACE).

We need to apply the lessons from the 1115 Waiver mandate to enroll seniors and people with disabilities (SPD) into Medi-Cal managed care, which uses a passive enrollment process. Since the mandate became effective, we have seen numerous problems ranging from lack of continuity of care to confusion about where SPDs can and cannot get care. Any savings from marketing a plan would be wiped out by solving these problems as well as dealing with beneficiaries' frustrations and anger, which are not measurable.

We oppose a lock-in enrollment of any period because it contradicts the goal of self-directed care and because it takes away rights and options that dually eligible beneficiaries currently have. Dually eligible beneficiaries currently are allowed to change Medicare Advantage and Part D plans once a month throughout the year, unlike beneficiaries who have Medicare only. This exception is based on the recognition that dually eligible beneficiaries have higher needs and changing health care needs. The Dual Eligibles Demonstration Project should preserve or enhance beneficiaries' rights and options, not take them away.

- Page 11, Pharmacy benefits

We recommend more specific guidance on formularies. Sites should provide the same prescription drug benefits that dually eligible beneficiaries receive now under Medicare Part D and Medi-Cal (for drugs not covered by Part D). If sites are required to comply with Medicare Part D rules and regulations, they should be provided the references and encouraged to join lists to receive updates on Medicare Part D. Similarly, sites should have references to Medi-Cal rules regarding Medi-Cal-covered drugs.

We would also like more details on the financing of the prescription drug benefit. All dually eligible beneficiaries now have the low income subsidy or Extra Help. They pay a statutory copayment for Medicare Part D-covered drugs and nothing for drugs covered by Medi-Cal. They should not have to pay more in a dual demonstration plan than what they would pay with Extra Help and under Medi-Cal.

We again express our appreciation for the opportunity to comment on the RFS and participate in the process of developing better models of care for our dually eligible population. If you have questions about these comments, please contact me at 510-885-1995 or eweakin@cahealthadvocates.org.

Sincerely,

Elaine Wong Eakin
Executive Director

Cal PACE
Community Leaders for California's Seniors

AltaMed
Senior BuenaCare
Los Angeles

Center for Elders
Independence
Oakland

On Lok
Lifeways
San Francisco

St. Paul's PACE
San Diego

Sutter SeniorCare
Sacramento

1333 Bush Street
San Francisco, CA 94109
1-888-633-PACE (7223)
www.calpace.org

January 9, 2012

Mr. Toby Douglas
Director
Department of Health Care Services
1501 Capitol Avenue, Suite 6001
Sacramento, CA 95814

Attn: DHCS Office of Medi-Cal Procurement

RE: Comments on Draft Request for Solutions for California's Dual Eligibles Demonstration Project

Dear Mr. Douglas:

Thank you for the opportunity to provide comments on the Department of Health Care Service's draft request for solutions (RFS) for the dual eligibles demonstration project.

CalPACE supports many of the goals of the dual eligible pilots, specifically those related to improving the coordination and integration of care for California's dual eligible population. As managed care providers with extensive experience serving this population we believe we have much to offer to help the state achieve its objectives of improving care and reducing the costs of serving this population. PACE programs currently serve the most frail among the dual eligibles, those who are over age 55 who are eligible for nursing home placement at the point they enroll in our programs. PACE programs provide the full array of acute care and long-term care support services that are covered by Medicare and Medi-Cal. They are at risk for, and pay for, any and all services needed by enrollees, including many services that are not covered services under Medicare and Medicaid, under capitated payments that do not change based on the level of care needed by enrollees. PACE programs are highly successful in helping beneficiaries remain in their homes and communities, through careful management of chronic conditions and timely access to a full array of home and community-based services.

CalPACE represents the five operational PACE programs in California, as well as two PACE programs that are expected to become operational in 2012, operated by Los Angeles Jewish Home and CalOptima. Eight additional organizations have filed letters of intent or applications to become PACE programs, and several existing PACE programs have filed applications to open new PACE centers, indicating that PACE is a successful model of care for persons who meet PACE eligibility requirements.

Comments on RFS

CalPACE supports several elements of the RFS document:

Benefits (Page 10): Specifically, we support requiring participating plans to provide or arrange for all Medicare and Medi-Cal covered services, and allowing them to provide other services needed to keep enrollees safely in the community (Page 11).

Geographic Coverage (Page 10): We also support starting the pilot in a limited number of counties, and specifically support the four county approach outlined in the RFS. Given the experiences from the transition of seniors and persons with disabilities to mandatory managed care, we believe there are a number of challenges inherent in the transfer of dual eligibles from fee-for-service to managed care plans and programs that will take time to work out, believe there is much that can be learned from a carefully focused pilot.

PACE as a separate program (Page 10): Finally, we support the language in the draft RFS providing that PACE will remain as a separate program, with enrollees able to choose it in the counties where PACE exists.

While we support these elements of the draft RFS, we believe several elements of the draft RFS need more clarification and elaboration in order to ensure that the ability of beneficiaries to choose to enroll in PACE, both initially and as their needs change, is preserved.

Demonstration Population (Page 9): The draft document states that DHCS is seeking comments on whether the demonstration should exclude beneficiaries who have been institutionalized for longer than 90 days. We understand the department's intent is to exclude beneficiaries who already have been institutionalized for longer than 90 days, rather than exempting beneficiaries who, once enrolled in the pilot, become institutionalized for more than 90 days. However, if the department decides to provide the latter, we urge you to allow beneficiaries who are enrolled in plans, who are eligible for PACE, to disenroll from the plans and enroll in PACE before they are placed in a nursing facility, in order to give them an opportunity to remain in the community.

Enrollment (Page 9): We strongly support allowing all beneficiaries to make an informed choice of what type of plan or program to enroll in, including remaining in fee-for-service Medi-Cal if that is their choice. We believe the RFS should make it clear that passive enrollment can only be applied if beneficiaries have been presented up front with balanced information on all of their choices, including PACE if it is available, and have not made an election of how to receive services.

We also support the creation of a single point of entry and independent screening and assessment process, to identify dual eligibles who have significant care needs and refer them to plans and programs that are best able to meet their needs. Through this process, dual eligibles who appear to meet the PACE eligibility requirements would receive additional information about PACE and be given an option to enroll in PACE at the point of initial enrollment.

PACE as a separate program (Page 10): In order for beneficiaries to have the opportunity to enroll in PACE, we strongly believe that PACE must be presented as an enrollment option and included in all enrollment materials, enrollment assistance programs, and outreach programs related to the dual pilots, and must presented to beneficiaries at each point of contact in which enrollment choices and options are made available. As we have previously commented, these measures have not been included in the transition of seniors and persons with disabilities to managed care under the state's existing Section 1115 waiver. As a result, many beneficiaries who could benefit from PACE and who would opt to enroll in PACE, do not learn that it is an option in their geographic area.

Finally, we support allowing beneficiaries who are enrolled in plans, who meet the eligibility requirements for PACE, to disenroll from the plans and enroll in PACE at the point they are eligible for

PACE, while they are still living in the community and before they have entered a nursing home. We believe plans should be required to assess enrollees and to notify those who appear to be eligible for PACE programs that they have the option to do so. The RFS should provide a clear process for this to occur and should require plans to explain in their applications how they will coordinate with PACE programs on these transitions.

We also believe beneficiaries who voluntarily disenroll from plans who are eligible for PACE should be informed of their ability to enroll in PACE before they disenroll, to provide an opportunity for them to consider continuation in models of integrated care.

We recognize that not all duals who are eligible to enroll in PACE will choose to do so, but for a significant portion of them, PACE will be the best option for them. Experience with the transition of seniors and persons with disabilities to managed care suggests that without these provisions, many dual eligibles who are enrolled in plans will enter nursing homes and many will eventually disenroll from the plans and return to fee-for-service Medi-Cal. At that point, many will no longer be able to be cared for in the community, even by PACE programs.

Thank you for the opportunity to provide these comments.

Sincerely,

Peter Hansel
Executive Director
CalPACE
1315 I St. Suite 100
Sacramento, CA 95814
916-469-3368
phansel@calpace.org

California Association of Physician Groups

January 9, 2012

Email: omcprfp9@dhcs.ca.gov.

Department of Health Care Services
Procurement Office
P.O. Box 997413
Sacramento, CA 95899-7413

Re: Comments on Draft Request for Solutions (RFS)

The California Association of Physician Groups (CAPG) is a trade association comprised of over 150 of the leading multispecialty medical groups and independent practice associations in California. Collectively, these physician owned and led organizations serve more than 18 million Californians, more than half the insured population of this state. CAPG is pleased to offer comments on the draft Request for Solutions.

The draft fails to meet the letter and the spirit of the underlying legislation and federal waiver that authorized four county pilots under the Bridge to Reform.[i] In so doing, the DHCS has created insurmountable barriers to entry for some of the most advanced and highly-regarded networks and delivery systems who have demonstrated the capability and capacity to provide coordinated patient care for the Dual Eligible population in this state for over a decade.

Generally speaking, the qualification criteria have been drawn in such a manner that only existing Medi-Cal managed care plans would qualify for the pilots. No provision is being made for the directly-contracted models that are currently being implemented here in California by the federal government. In particular, we note three key examples that illustrate this conclusion:

- Page 17: All applicants must possess an ***unrestricted*** Knox-Keene license. This excludes a number of experienced, financially solvent physician groups who currently provide care to Dual Eligible patients through the Medicare Advantage program and who have demonstrated the capacity to assume financial risk for this population, while producing superior outcomes and cost-savings to the federal government. Since Medi-Cal is a government sponsored program, a full Knox Keene license is not necessary. Limited licenses or modified restricted licenses would serve, since no marketing capability is needed by the potential demonstration sites.[ii]

Los Angeles Office
915 Wilshire Blvd., Suite 1620
Los Angeles, California 90017
Telephone: 213-624-CAPG (2274)
FAX: 213-683-0032

Sacramento Office
1215 "K" Street, Suite 1915
Sacramento, California 95814
Telephone: 916-443-CAPG (2274)
FAX: 916-442-4975
www.capg.org

- Page 18: All applicants must show experience operating a D-SNP (special needs plan). Several potential applicants for this process have formed the delivery system for such D-SNPs for years, and in fact have experience providing the *actual care* to Dual Eligible patients and have taken financial risk contracts for doing so. They would be excluded, and yet, under the present language, entities who *have not provided* such care in the past could merely certify that they will work in good faith to meet such criteria in the future.[iii]
- Page 18: All applicants must posses a current Medi-Cal managed care contract with DHCS – thereby excluding any applicants who may provide more innovative, cost-effective proposals through alternative delivery system models, such as provider-sponsored Accountable Care Organizations, or Risk Bearing Organizations who could contract directly with the state.[iv]

SB 208 provided for flexibility in the potential piloted models. The underlying premise of SB 208 was such that any future provisions under the federal waiver would govern. In its letter of July 8, 2011, the CMS outlined both a capitated and a managed fee-for-service payment model available to the 15 states who were awarded the Duals integration pilots.[v] With regard to the capitated model, the letter is explicit, stating at page 2, footnote 2 that "eligible health plans" may include both current and "other eligible entities assuming they can meet all applicable standards, as agreed upon in writing by CMS and the State." The managed fee-for-service model tracks very closely with the process in the Pioneer Accountable Care Organization model.

CAPG speaks for its entire membership in this matter, but it is important to note that the federal government, through its Center for Innovation under the CMS, recently awarded six Pioneer Accountable Care Organization (ACO) pilots to CAPG member physician groups based in California.[vi] There are only 32 such awardees nationally, and these six CAPG member groups will comprise roughly 18% of the total number of pilots across the United States. Provider-operated entities that actually provide the care to Dual Eligible patients (and other seniors) have the most experience in delivering superior quality of care, greater coordination of patient care and with lower cost to the system derived through the efficiencies that they produce. This is why the federal government awarded six California CAPG members to serve as Pioneer ACOs.

Collectively, the California Pioneers will be responsible for approximately 300,000 traditional Medicare senior patients in California over the next three years under this new and innovative program. According to the most recent formulas, the Pioneers have been informed to expect that up to 21 percent of their incoming patient population for 2012 will be Dual Eligible. If this plays out as expected, the six Pioneers will treat approximately 63,000 Dual Eligibles assigned to them during 2012 through the CMS.[vii] Currently, the six Pioneers have an additional Dual Eligible population of roughly 22,000 patients through their current Medicare Advantage contracts. If one adds the two Permanente medical groups to this list (also CAPG members), the number increases to over 75,000 Dual Eligibles under care.

It is not an overstatement to say that just this small subset of Six CAPG member groups has far more experience providing the kind of coordinated patient care to Dual Eligible patients than most of the other potential applicants under this RFS, and they have developed this experience over a decade of service to this patient population.

It is also important to note that a key goal of the Duals integration pilot is maximize continuity of care. Care delivery models that cut out middlemen function more efficiently. Care delivery models that impose one or more middlemen, such as a county health plan that subcontracts to a commercial health plan imposes unnecessary layers of administrative overhead and in practice, interferes with continuity of care. A good example exists in the recent provider experience during the 2011 roll-out of the mandatory managed care enrollment of Seniors and Persons with Disabilities. CAPG conducted a survey of 22 of its member physician organizations, who collectively have over 1 million Medi-Cal managed care patients assigned to them. Communication of continuity of care information to the treating provider was virtually non-existent. Out of 67,000 assigned SPD patients, treating providers only received continuity of care information for 6-7 percent of the assigned patient population.

The RFS should be amended to permit Risk-Bearing-Organizations with a proven track record of caring effectively for Dual Eligible patients under Medicare Advantage in California to qualify as applicants for one or more of the demonstration sites. This may include federally-registered Accountable Care Organizations, but should not be limited to such entities.

The draft RFS does not incorporate direct contracting strategies through ACOs or RBOs that are currently being pursued by the federal government for over 300,000 Medicare Senior patients in this state and which will incorporate up to 60,000 Dual Eligible patients in 2012. The RFS as currently drawn largely ignores the direction being taken by the Innovations Center at CMS, putting this state a generation behind where other states and the federal government intend to go over the next five years in better integrating delivery systems and achieving coordinated patient care. Is it wise to exclude such a potentially advantageous delivery system from this RFS?

Sincerely,

William Barcellona
Sr. V.P. Government Affairs

---

[i] SB 208 provided for up to four county pilots and stated: "(f) The director may enter into exclusive or nonexclusive contracts on a bid or negotiated basis and may amend existing managed care contracts to provide or arrange for services provided under this section. Contracts entered into or amended pursuant to this section shall be exempt from the provisions of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of the Government Code."

[ii] The key difference between a full or unrestricted Knox Keene license and a limited license or restricted license is that the entity may not sell or otherwise market coverage to the enrollee. In a government sponsored program, that is irrelevant. It is material to commercial coverage only.

[iii] Qualification Requirements, Subparagraph 3 at page 18 states: "must certify that it will work in good faith to meet all the D-SNP requirements in that County in the next year."

[iv] In fact, this proposal adds greater administrative costs to the system by requiring in most cases that a two-plan model applicant will have double the administrative cost layer. This is directly contrary to the current direction

being taken by CMS in creating directly-contracted ACOs to serve the Medicare population that *eliminate* the HMO administrative layer.

[v] See attached letter of July 8, 2011 to State Medicaid Directors (Excerpted).

[vi] See attached CMS press release of December 19, 2011.

[vii] Oddly enough, these Dual Eligible patients would be disrupted from their care under the six Pioneer ACOs at the end of 2012, if the current State plan moves forward as proposed under the RFS.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid, CHIP and Survey & Certification
Medicare-Medicaid Coordination Office

SMDL# 11-008
ACA# 18

July 8, 2011

Re: Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees

Dear State Medicaid Director:

This letter provides preliminary guidance on opportunities to align financing between Medicare and Medicaid to support improvements in the quality and cost of care for individuals enrolled in both programs (also referred to as "Medicare-Medicaid enrollees" or "dual eligibles"). Specifically, the Centers for Medicare & Medicaid Services (CMS) is outlining two models for States pursuing integration of primary, acute, behavioral health and long term services and supports for their full benefit Medicare-Medicaid enrollees.

Section 2602 of the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), together known as the Affordable Care Act, created the Federal Coordinated Health Care Office ("Medicare-Medicaid Coordination Office"). The Medicare-Medicaid Coordination Office is charged with making the two programs work together more effectively to improve care and lower costs. Specifically, pursuant to section 2602(c) of the Affordable Care Act, the Office is focused on improving quality and access to care for Medicare-Medicaid enrollees; simplifying processes; and eliminating regulatory conflicts and cost-shifting that occurs between the Medicare and Medicaid programs, States, and the Federal government.

In partnership with States, CMS is improving the quality of care Medicare-Medicaid enrollees receive by expanding access to seamless, integrated programs. The first initiative in this area, the State Demonstrations to Integrate Care for Dual Eligible Individuals, was launched in April 2011[1] through the Center for Medicare and Medicaid Innovation ("Innovation Center"). CMS is working with fifteen States, competitively selected based on their advanced readiness, to design person-centered approaches to better coordinate care for Medicare-Medicaid enrollees. The overall goal of this initiative

[1] CMS has subsequently launched two additional initiatives to support States' efforts to improve the quality and costs of care for Medicare-Medicaid enrollees: the availability of Medicare Parts A, B, and D data to States for care coordination purposes and the Alignment Initiative. For more information on all of these initiatives, please see http://www.cms.gov/medicare-medicaid-coordination.

is to develop, test and validate fully integrated delivery system and care coordination models that can be replicated in other States. Early work with these States confirms that a key component of such initiatives will be testing new payment and financing models to promote better care and align the incentives for improving care and lowering costs between Medicare and Medicaid.

This letter provides guidance on two financial alignment models that CMS seeks to test with States. Through the Innovation Center, CMS is interested in testing these models across the country in programs that collectively serve up to 1-2 million Medicare-Medicaid enrollees. The models are open to the fifteen States participating in the above mentioned State Demonstrations to Integrate Care for Dual Eligible Individuals as well as any other State that demonstrates it can meet the established standards and conditions and would be ready to implement its proposed demonstration by the end of 2012. Under these models, CMS will work with interested States to combine Medicare and Medicaid authorities to test a new payment and service delivery model to reduce program expenditures under Medicare and Medicaid while preserving or enhancing the quality of care furnished to Medicare-Medicaid enrollees in this capitated program. Demonstrations under this program would be limited to no more than three years. All demonstrations will include a rigorous evaluation, the results of which will help inform the potential for future program changes.

CMS is offering streamlined approaches for States interested in testing these two models and technical assistance to support necessary planning activities.

The first model is a capitated approach to integration for Medicare-Medicaid enrollees; the second is a managed fee-for-service (FFS) approach to integration. Under the capitated model, CMS, the State, and health plans[2] would enter into a three-way contract; the participating plans would receive a prospective blended payment to provide comprehensive seamless, coverage. This model will target aggregate savings through actuarially developed blended rates that will provide a new savings opportunity for both States and the Federal government. Under the managed FFS model, CMS and a State will enter into agreement whereby the State would be eligible to benefit from savings resulting from initiatives that improve quality and reduce costs for both Medicaid and Medicare. These models provide States with two new pathways to support integration for Medicare-Medicaid enrollees and provide opportunities to achieve savings as a result of improvements in care delivery. States meeting the necessary criteria will have an option to pursue either or both of these financial alignment models.

This letter provides initial information on aspects of these two models. It is intended to provide sufficient detail to allow States to determine their interest in testing these models and to begin necessary planning activities. Interested States should submit a Letter of Intent, as described below, to initiate the process.

---

[2] Eligible health plans include entities currently offering Medicare Advantage or Medicaid managed care and could include other eligible entities assuming they can meet all applicable standards, as agreed upon in writing by CMS and the State.

While this guidance focuses on the new financial alignment model demonstration opportunities, The Medicare-Medicaid Coordination Office is available to provide technical assistance and access to a Resource Center for all States in support of efforts to improve the quality and cost effectiveness of care for Medicare-Medicaid enrollees.

General Information

Throughout this guidance, there will be references to an "integrated program," which refers to one that encompasses all the medical, behavioral health, and long-term services and supports needed by an individual eligible for both Medicare and Medicaid. CMS is pursuing integrated programs because a comprehensive approach will ensure that the individual has a seamless care experience and that one entity is accountable for the full continuum of care for the Medicare-Medicaid enrollee.

Implementation of these models will rely on effective partnerships with States and success will largely be contingent upon engagement with and the capacity of health care and service providers that support and care for Medicare-Medicaid enrollees in their communities. Medicare-Medicaid enrollees, their families and consumer organizations working with them also have a central role to play in helping to design a person-centered system of care. Therefore, CMS encourages and expects active and meaningful State engagement with stakeholders in both models.

Background

There are over 9 million Medicare-Medicaid enrollees, more than two-thirds of whom receive full benefits from both programs.[3] While Medicare-Medicaid enrollees comprise only 16 percent of Medicare and 15 percent of Medicaid enrollees, they account for 27 percent and 39 percent of total Medicare and Medicaid spending respectively.[4] The majority of these beneficiaries receive their care in uncoordinated systems, which may result in poor quality, or costly care. A priority for CMS and the Department is to significantly increase the number of Medicare-Medicaid enrollees in seamless coordinated care systems that will improve beneficiary experiences and quality outcomes, while also achieving savings for both States and the Federal government.

A longstanding barrier to integration for Medicare-Medicaid enrollees has been the financial misalignment between Medicare and Medicaid. Reforms to improve quality and reduce costs require an investment in the delivery system and care management. Because delivery of services for Medicare-Medicaid enrollees is split between Medicare and Medicaid, States may lack incentives to invest in such initiatives. As a result, these

---

[3] Based on the Centers for Medicare &Medicaid Services (CMS) Enrollment Database, Provider Enrollment, Economic and Attributes Report, provided by CMS Office for Research, Development and Information, July 2010.

[4] The Medicare Payment Advisory Committee, A Data Book: Healthcare spending and the Medicare program, June 2010 and Kaiser Family Foundation, The Role of Medicare for the People Dually Eligible for Medicare and Medicaid. January 2011.

beneficiaries, arguably those who could benefit the most from an investment in care coordination, are generally excluded from such State programs.

To address this challenge, CMS is announcing two models that will provide opportunities to improve quality and the beneficiary experience while also reducing costs for both States and the Federal government. They are part of a broader agenda for the Medicare-Medicaid Coordination Office, CMS, and the Administration to improve the care, quality, cost, and, ultimately, health for this population.

Capitated Model

One approach to integration is to leverage the significant experience of States in utilizing capitated models to provide care for the Medicaid population. Currently, the most integrated systems for Medicare-Medicaid enrollees are funded through capitated arrangements, which have supported efforts to create flexible, person-centered systems of care. The Program of All Inclusive Care for the Elderly (PACE), Fully Integrated Dual Eligible Medicare Advantage Special Needs Plans, managed long-term care programs in Medicaid, and prior Medicare-Medicaid demonstrations provide important lessons. The capitated model described in this guidance builds on those experiences and is designed to address some of the remaining programmatic and fiscal challenges in current contracting models, and to ensure incentives are aligned to encourage States and plans to participate. Under this model, CMS will test a new capitated payment model utilizing a three-way contract among a State, CMS and health plans to provide integrated benefits to Medicare-Medicaid enrollees.

Plans will receive a blended capitated rate for the full continuum of benefits provided to Medicare-Medicaid enrollees across both programs. The capitated model will target aggregate savings through actuarially developed blended rates that will provide savings for both States and the Federal government. Plans will be required to meet established quality thresholds.

The three-way contract among CMS, the State, and health plans will also test administrative, benefit and enrollment flexibilities that will further the goal of providing a seamless experience for Medicare-Medicaid enrollees utilizing a simplified and unified set of rules. Such flexibilities will vary by State and may include, but are not limited to: supplemental benefits; enrollment flexibilities; and a single set of appeals, auditing and marketing rules and procedures. Any flexibility will be coupled with specific beneficiary protections that will be included in the contract among the parties.

Plans will be selected through a competitive, joint procurement by States and CMS. CMS and the State will contract with selected high-performing health plans that demonstrate the capacity to provide to enrollees, directly or by subcontracting with other qualified entities, the continuum of Medicare and Medicaid covered services. CMS and the State will ensure that beneficiaries have access to an adequate network of medical and supportive service providers.

Managed FFS Model

Another approach to integration is to design programs built on the existing FFS delivery system. Many States have invested significant resources to organize their delivery system to provide coordinated care for Medicaid beneficiaries through a FFS model. In addition, new CMS programs focused on redesigning the primary care delivery system (e.g., Accountable Care Organizations, Medicaid health homes) offer opportunities for States to improve coordination of care within a managed FFS delivery model. Under this model, CMS will test the impact of establishing a retrospective performance payment to States based on Medicare savings achieved for Medicare-Medicaid enrollees. The State program will ensure seamless integration and access to all necessary services based on the individual's needs through coordination across the two programs. States would make the upfront investment in care coordination and would be eligible for a retrospective performance payment should a target level of savings result to Medicare. Savings determinations will be based on rigorous evaluation of Medicare and Medicaid spending in each State and must be certified by CMS Office of the Actuary (OACT).

States will be eligible for retrospective performance payments based on Medicare savings net of increased Federal Medicaid costs. Performance payments will only be made to States that meet or exceed established quality thresholds for the Medicare-Medicaid enrollees in the program.

Streamlined Process

States that are interested in pursuing these models are asked to submit a Letter of Intent to CMS to begin the planning process by October 1, 2011.

After notifying CMS of its interest to participate, a State will have to demonstrate that it has met or exceeded certain CMS established standards and conditions to begin the formal process of entering into a Memorandum of Understanding (MOU) between the State and CMS. The standards and conditions, which will be provided through supplemental guidance for interested States, will ensure consistency across State initiatives, promote sound management, and ensure beneficiary protections. They may differ slightly between the two models; however, each will include:

- Public notice and meaningful consumer and other stakeholder engagement;
- Enrollment targets and related outreach initiatives;
- Integrated care management across primary, acute, behavioral health and long-term services and supports;
- OACT certifiable estimates of expected savings;
- Integrated beneficiary level claims data to inform program management and evaluation;
- Adequate access to networks of medical and supportive services providers;
- Monitoring and oversight infrastructure;
- Quality measurement infrastructure; and

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
200 Independence Avenue, SW
Washington, DC 20201
Office of Communications

FACT SHEET

FOR IMMEDIATE RELEASE
December 19, 2011

Contact: CMS Media Relations Group
(202) 690-6145

Pioneer Accountable Care Organization Model:
General Fact Sheet

The Pioneer ACO Model is a CMS Innovation Center initiative designed to support organizations with experience operating as Accountable Care Organizations (ACOs) or in similar arrangements in providing more coordinated care to beneficiaries at a lower cost to Medicare. The Pioneer ACO Model will test the impact of different payment arrangements in helping these organizations achieve the goals of providing better care to patients, and reducing Medicare costs.

Accountable Care Organizations

Accountable Care Organizations (ACOs) are one way CMS is working to ensure better health care, better health, and lower growth in expenditures through continuous improvement.

The Medicare Shared Savings Program provides incentives for ACOs that meet standards for quality performance and reduce cost while putting patients first. Established by the Affordable Care Act, CMS published final rules for the Shared Savings Program on November 2, 2011. More information is available at www.cms.gov/sharedsavingsprogram.

Working in concert with the Shared Savings Program, the Innovation Center is testing an alternative ACO model, the Pioneer ACO Model. The Innovation Center is also testing the Advance Payment ACO Model, which will provide additional support to physician-owned and rural providers participating in the Shared Savings Program who would benefit from additional start-up resources to build the necessary infrastructure, such as new staff or information technology systems.

More information on all of these initiatives is available on the Innovation Center website at www.innovations.cms.gov.

The Pioneer ACO Model and Selected Organizations

The Pioneer ACO Model was designed specifically for organizations with experience offering coordinated, patient-centered care, and operating in ACO-like arrangements. The selected organizations were chosen for their significant experience offering this type of quality care to their patients, along with other criteria listed in the Request for Applications (RFA) document available at www.innovations.cms.gov. These organizations were selected through an open and competitive process from a large applicant pool that included many qualified organizations.

The 32 organizations participating in the Pioneer ACO Model:

Organization	Service Area
1. Allina Hospitals & Clinics	Minnesota and Western Wisconsin
2. Atrius Health Services	Eastern and Central Massachusetts
3. Banner Health Network	Phoenix, Arizona Metropolitan Area (Maricopa and Pinal Counties)
4. Bellin-Thedacare Healthcare Partners	Northeast Wisconsin
5. Beth Israel Deaconess Physician Organization	Eastern Massachusetts
6. Bronx Accountable Healthcare Network (BAHN)	New York City (the Bronx) and lower Westchester County, NY
7. Brown & Toland Physicians	San Francisco Bay Area, CA
8. Dartmouth-Hitchcock ACO	New Hampshire and Eastern Vermont
9. Eastern Maine Healthcare System	Central, Eastern, and Northern Maine

10. Fairview Health Systems	Minneapolis, MN Metropolitan Area
11. Franciscan Health System	Indianapolis and Central Indiana
12. Genesys PHO	Southeastern Michigan
13. Healthcare Partners Medical Group	Los Angeles and Orange Counties, CA
14. Healthcare Partners of Nevada	Clark and Nye Counties, NV
15. Heritage California ACO	Southern, Central, and Costal California
16. JSA Medical Group, a division of HealthCare Partners	Orlando, Tampa Bay, and surrounding South Florida
17. Michigan Pioneer ACO	Southeastern Michigan
18. Monarch Healthcare	Orange County, CA
19. Mount Auburn Cambridge Independent Practice Association (MACIPA)	Eastern Massachusetts
20. North Texas Specialty Physicians	Tarrant, Johnson and Parker counties in North Texas
21. OSF Healthcare System	Central Illinois
22. Park Nicollet Health Services	Minneapolis, MN Metropolitan Area
23. Partners Healthcare	Eastern Massachusetts
24. Physician Health Partners	Denver, CO Metropolitan Area

25. Presbyterian Healthcare Services – Central New Mexico Pioneer Accountable Care Organization	Central New Mexico
26. Primecare Medical Network	Southern California (San Bernardino and Riverside Counties)
27. Renaissance Medical Management Company	Southeastern Pennsylvania
28. Seton Health Alliance	Central Texas (11 county area including Austin)
29. Sharp Healthcare System	San Diego County
30. Steward Health Care System	Eastern Massachusetts
31. TriHealth, Inc.	Northwest Central Iowa
32. University of Michigan	Southeastern Michigan

The Innovation Center

The Innovation Center was created by the Affordable Care Act to test new models of health care delivery and payment. The Center also offers technical support to providers to improve the coordination of care and share lessons learned and best practices throughout the health care system. It is committed to refining the Medicare, Medicaid and CHIP programs to deliver better care for individuals, better health for populations, and lower growth in expenditures.

Payment Arrangement and Beneficiary Alignment

The first performance period begins in January 1st, 2012. In the first two performance years, the Pioneer Model tests a shared savings and shared losses payment arrangement with higher levels of reward and risk than in the Shared Savings Program. These shared savings would be determined through comparisons against an ACO's benchmark, which is based on previous CMS expenditures for the group of patients aligned to the Pioneer ACO

In year three of the program, those Pioneer ACOs that have shown savings over the first two years will be eligible to move to a population-based payment model. Population-based payment

is a per-beneficiary per month payment amount intended to replace some or all of the ACO's fee-for-service (FFS) payments with a prospective monthly payment.

Additionally, during the application process, organizations were invited to propose alternative payment arrangements. CMS established two alternatives to the core payment arrangement discussed above based on this input. Both of these alternatives follow a shared savings model in years one and two, and provide an option for a partial population based payment that removes limits on rewards and risks in year three. These arrangements will allow Pioneer ACOs more flexibility in the speed at which they assume financial risk.

Under the Pioneer ACO Model, CMS will prospectively align beneficiaries to ACOs, allowing care providers to know at the beginning of a performance period for which patients' cost and quality they will be held accountable.

Beneficiary Protections and Quality Measures

Providing the beneficiary with a better care experience is one of the central focuses of the Pioneer ACO Model. Under the Pioneer ACO Model, beneficiaries will maintain the full benefits available under traditional Medicare (fee-for-service), as well as the right to receive services from any healthcare provider accepting Medicare patients.

To ensure beneficiaries receive high quality care and enjoy a positive experience, CMS has established robust quality measures that will be used to monitor the quality of care provided and beneficiary satisfaction. These measures mirror those in the Shared Savings Program. For more information, visit www.cms.gov/sharedsavingsprogram and view the fact sheet entitled "Improving Quality of Care for Medicare Patients: Accountable Care Organizations."

More information about beneficiary protections and quality measures is available in the fact sheet entitled "The Pioneer ACO Model: A Better Care Experience Through a New Model of Care."

Eligibility Criteria/Program Requirements

To be eligible to participate in the Pioneer ACO Model, organizations are required to be providers or suppliers of services structured as:

1) ACO professionals in group practice arrangements;
2) Networks of individual practices of ACO professionals;
3) Partnerships or joint venture arrangements between hospitals and ACO professionals;
4) Hospitals employing ACO professionals; or
5) Federally Qualified Health Centers (FQHC).

Health Information Technology

By the end of 2012, Pioneer ACOs must attest and CMS will confirm that at least 50% of the ACO's primary care providers have met requirements for meaningful use of certified electronic health records (EHR) for receipt of payments through the Medicare and Medicaid EHR Incentive Programs.

Minimum Number of Aligned Beneficiaries

Beneficiaries are aligned to ACOs through the healthcare providers that choose to participate. CMS will review where a beneficiary has been receiving the plurality of his/her primary care services, and use that information to establish which beneficiaries are aligned to a participating provider. If a primary care provider chooses to participate in an ACO, the beneficiaries aligned to him or her through this process would be aligned to the ACO. If a beneficiary receives less than 10 percent of their care from a primary care provider, CMS will review where a beneficiary has been receiving the majority of his/her specialty services to determine alignment.

Participants generally must have a minimum of 15,000 aligned beneficiaries unless located in a rural area, in which case are to have a minimum of 5,000 beneficiaries. In order to be aligned, beneficiaries must be enrolled in original, fee for service Part A and B Medicare. They cannot be participating in Medicare Advantage plans.

Participation of Other Payers

The Innovation Center believes that Pioneer ACOs will be more effective in producing improvements in three part aim of better care for individuals, better health for populations, and slower growth in expenditures if they fully commit to a business model based on financial and performance accountability. The Innovation Center therefore requires Pioneer ACOs to enter similar contracts with other payers (such as insurers, employer health plans, and Medicaid) such that more than 50 percent of the ACO's revenues will be derived from such arrangements by the end of the second Performance Period.

Selection Process

CMS conducted a lengthy, open and competitive application process to select the final participants in the Pioneer ACO Model. CMS released a Request for Applications (RFA) in May 2011 that detailed the selection criteria. Applicants were required to submit both a Letter of Intent and Application. Applications were reviewed by a panel of experts from the Department of Health and Human Services as well as from external organizations, with expertise in the areas of provider payment policy, care improvement and coordination, primary care, and care of vulnerable populations. These panels assessed the applications based on the criteria detailed in the RFA. Applicants with the highest scores were invited to participate in interviews with Innovation Center leadership at the CMS facility in Baltimore. Based on these interviews, CMS

chose a pool of finalists. The Pioneer ACOs announced in December 2011 were those finalists choosing to sign a final agreement with CMS.

Pioneer ACO Model and the Shared Savings Program

The Pioneer ACO Model is distinct from the Shared Savings Program. The Shared Savings Program fulfills a statutory obligation set forth by the Affordable Care Act to establish a permanent program that develops a pathway forward for groups of health care providers to become ACO's, while the Pioneer ACO Model is an initiative designed to test the effectiveness of a particular model of payment. Final rules for the Shared Savings Program were published in November 2011. More information is available at www.cms.gov/sharedsavingsprogram.

The Pioneer ACO Model differs from the Medicare Shared Savings Program in the following ways, among others:

- The first two years of the Pioneer ACO Model are a shared savings payment arrangement with higher levels of savings and risk than in the Shared Savings Program.
- Starting in year three of the initiative, those organizations that have earned savings over the first two years will be eligible to move to a population-based payment arrangement and full risk arrangements that can continue through optional years four and five.
- Pioneer ACOs are required to develop similar outcomes-based payment arrangements with other payers by the end of the second year, and fully commit their business and care models to offering seamless, high quality care.

Additional Information

Additional information about the Pioneer ACO Model is available on the Pioneer ACO Model website - http://www.innovations.cms.gov/initiatives/aco/pioneer

CALIFORNIA ASSOCIATION OF SOCIAL REHABILITATION AGENCIES

casra

PO Box 388 Martinez, CA 94553 Ph (925)229-2300 Fax (925)229-9088 casra@casra.org

January 9, 2012

Director's Office
Department of Health Care Services
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 95899

RE: Stakeholder feedback regarding DHCS Request For Solutions (RFS) for California's Dual Eligibles

Dear Director Douglas:

The California Association of Social Rehabilitation Agencies (CASRA), a statewide organization of private, not-for-profit, public benefit corporations that provide recovery-oriented services to clients of the California public mental health system, has identified the following items of concern in the DHCS Request For Solutions (RFS) for California's Dual Eligibles Demonstration Project:

- **Opposes Passive and Lock-In Enrollment** which will require participants to opt out of plans in which they are auto-enrolled. We are in favor of active enrollment whereby consumers have the right to choose a plan and are able to opt out at any time. (Enrollment Pages 7 & 26)
- **Beneficiary Protections** should be established from the onset in the event that pilot projects are not continued past the demonstration period. (Overview/Purpose Page 3)
- **Explicit Coordination** should be required of behavioral health and home and community based services for all beneficiaries. (Summary Page 9)
- **Exclusion of those institutionalized for more than 90 days** should be removed. Often institutionalization for more than 90 days is due to a lack of available housing and service options and these individuals should be able to access the full continuum of integrated care. (Population Page 7)
- **Pharmacy Benefits** should highlight the importance of coordinating formularies, prescribing and pharmacy network with county mental health for beneficiaries with mental illness. Furthermore, beneficiaries stable on medication regimen should be exempt from any new formulary restrictions. (Pharmacy Benefits Page 11)
- **IHSS Flexibility** and greater coordination of IHSS services and continued access to IHSS providers should be realized. (IHSS Page 9)
- **Substance Use Services** should not be a supplementary benefit as it is covered by Medicare. The frequent co-occurrence of substance use with physical and psychiatric disabilities requires substance use services be available. (Benefits Page 8)

- **Broad stakeholder participation** across the lifespan detailing specific activities must be ensured in spite of the aggressive timeline. (Stakeholder Involvement Page 20 and Stakeholder Input 26)
- **DRAFT Memorandum Of Understanding/Agreement with County Mental Health** should be a requirement of all proposals and not an element for additional consideration. (Criteria for Additional Consideration Page 17)
- **Limited pool of applicants.** The specific requirement to be currently operating managed care plans limits the applicant pool and should be removed. (D-SNP Requirements and Current Medi-Cal Managed Care Page 18)
- **Clarify the role of County Mental Health** after year one particularly related to covering all Medicare and Medi-Cal specialty services per the 1115 waiver as there is variance among counties in the provision of rehabilitation and recovery services. (Coordination and Integration of Mental Health and Substance Use Page 24)
- **Mental Health Services** should be required to be integrated in year one, rather than the final year of the demonstration. (Care Coordination Page 9)

We appreciate the opportunity to provide feedback on the RFS and look forward to working together on the development of this important program to support California's dually eligible beneficiaries.

Sincerely,

Joseph Robinson, LCSW CADAC II
Associate Director for Public Policy
California Association of Social Rehabilitation Agencies (CASRA)
P. O. Box 388 Martinez, CA 94553
(925) 229-2300
www.casra.org

Center for Health Care Rights
ADVOCACY FOR HEALTH CARE CONSUMERS

January 9, 2012

Toby Douglas, Director
Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413

Filed electronically: OMCPRFP9@dhcs.ca.gov

Comments on Draft Request for Solutions (RFS) for California's Dual Eligibles Demonstration Project

Dear Mr. Douglas:

The Center for Health Care Rights (CHCR) submits these comments to DHCS' draft Request for Solutions (RFS) for California's Dual Eligibles Demonstration Project.

The Center for Health Care Rights (CHCR) is a non-profit health care advocacy organization dedicated to improving consumer access to quality health care. As an integral part of this mission, CHCR provides Medicare advocacy and health insurance counseling services to Medicare beneficiaries and their families in Los Angeles County. Since 1985, CHCR has served as the Health Insurance Counseling and Advocacy Program contractor for the City and County of Los Angeles. As the HICAP contractor, CHCR is also the SHIP contractor for Los Angeles. CHCR also receives funding by the State Bar of California Legal Services Trust Fund Program to provide Medicare legal services to low income dual eligible Medicare/Medicaid beneficiaries.

The Center for Health Care Rights has significant experience with the dual eligible population in Los Angeles County. More than 25% of all dual eligibles in California reside in Los Angeles County. On a daily basis, our agency sees first hand the obstacles that dual eligibles encounter navigating the complex system of Medicare and Medicaid coverage. As the current data on dual eligible documents, dual eligibles are more likely to have multiple chronic conditions, suffer from mental illness and/or cognitive impairment, and reside in institutional settings. In addition, dual eligibles are also more likely to have low literacy and to have limited English proficiency.

These comments present our recommendations for key principles that should be used to develop and select effective Demonstration sites that will be able to provide the effective delivery of care to dual eligibles.

I. Demonstration Model Summary

Key Attributes

1. Demonstration Population:

The demonstration project should include individuals who have HIV/AIDS, End-Stage Renal Disease (ESRD), Amyotrophic Lateral Sclerosis (ALS), and individuals who have been institutionalized for more than 90 days, but only if participation for these individuals is purely voluntary. Because of the complexity of these situations, individuals who have one of these listed conditions or who are institutionalized should be not be locked into a demonstration project for any period of time or passively enrolled into the Demonstration. While we oppose both passive enrollment and a lock-in period for all dual eligibles, we would suggest that if these models are adopted, that duals with any of these listed conditions or who are institutionalized for more than 90 days be exempted from passive enrollment and any lock-in period. Instead we suggest they be offered the opportunity to voluntarily opt in to the Demonstration.

2. Enrollment:

We support a voluntary/"opt-in" enrollment model rather than a passive enrollment/"opt-out" model for the Demonstration sites. This allows beneficiaries to preserve the right to choose their providers and the manner in which they receive care. It also allows dual eligibles who have complex medical conditions to access providers they may not be able to under an integrated care model. In addition, given the mental health, cognitive health, literacy, and language access issues many dual eligibles face, an "opt-out" model may prove to be too difficult for them to navigate. Based on CHCR's experience with Medicare Part D and dual eligibles, which is essentially an "out-out" model, we find that duals undergo a very difficult transition from Medi-Cal drug coverage to Part D coverage. Many duals who are auto-assigned to a Part D plan do not realize there has been change in their drug coverage and that they have been auto-assigned to a Part D plan, and do not understand how to obtain drug coverage through their auto-assigned drug plan. In addition, many dual eligibles remain in auto-assigned plans that do not cover all their medications even though they are experiencing drug access issues because they do not understand how to change plans, and are only able to do so with outside assistance.

We have also seen numerous issues with the transition to mandatory managed care enrollment for Seniors and Persons with Disabilities (SPD) which uses a model that defaults SPDs into Medi-Cal managed care plans if they do not select a plan on their own. We have encountered numerous SPD beneficiaries who experience serious continuity of care issues because they have been defaulted into a plan they know little

about. We anticipate that if a passive enrollment model is adopted for the Demonstration that many dual eligibles will face similar problems.

Overall, passive enrollment models are too significant a change to be imposed on a large scale. If passive enrollment models are adopted, they should only be adopted after a phased-in process which results in quantifiable improvements to integrated and coordinated care for dual eligibles.

We also oppose any type of enrollment lock-in for duals in the Demonstration. Lock-in prevents beneficiaries from exercising the right to choose their providers and the manner in which they receive their health care. Imposing a lock-in period would also treat dual eligibles in the Demonstration differently than other dual eligibles who are entitled to a continuous Medicare Part D Special Enrollment Period (SEP) that provides them with the ability to change their Medicare Part D enrollment on a monthly basis. Dual eligibles enrolled in the Demonstration project should have all the same rights and protections afforded to other dual eligibles.

A passive enrollment model and a lock-in period are flawed methods of ensuring sufficient participation in the Demonstration project precisely because it takes away beneficiary choice. The best way to ensure sufficient participation in the Demonstration project is through an attractive benefits package and a robust provider network that provides a high quality of care, and strong care coordination.

The Draft RFS leaves a number of questions regarding enrollment issues unanswered that should be clarified in the final RFS. These include:

1. Which entity will be responsible for processing enrollments and disenrollments? Will DHCS, CMS, or the Demonstration sites be responsible for enrollments?

2. Will Health Care options be responsible for enrollments and disenrollments?

3. Will a separate entity be created to process enrollments and disenrollments?

4. Will dual eligibles who are already enrolled in Medicare Advantage plans be exempted from the Demonstration project?

3. Geographic Coverage:

We suggest that DHCS avoid selecting Demonstration sites in large counties like Los Angeles, San Diego and Alameda that do not operate under a County Organized Health System (COHS). Implementing a pilot project in large counties with extremely diverse and challenging dual eligible populations poses a number of issues for Demonstration sites. These large counties tend to be very geographically spread out and are more likely to have dual eligible beneficiaries with more complex medical

conditions and who speak multiple languages. The relatively short transition time when DHCS expects that individuals will be enrolled into the Demonstration sites in 2013, provides the selected sites with little time to adequately prepare for such large and complex populations. The level of integration proposed in the RFS does not exist in any current model. We would encourage DHCS to take a more gradual approach to developing the Demonstration by selecting counties with more manageable dual eligible populations. If a large county is selected, we would suggest that the Demonstration site only serve a discrete geographic area in that county based on zip code. We would also suggest that the Demonstration not be expanded to more than four counties at this time.

4. Integrated Financing:

An integrated financing model should not shift financial responsibility from Medi-Cal to Medicare for Medi-Cal covered services. An integrated financing model must include adequate incentives for plan participation and provide for competitive provider reimbursement to ensure that Demonstration sites will have robust provider networks and provide access to specialty services for such a high-need population. An integrated financing model should also provide incentives for providing participants with home and community based services that allow participants to remain safely in the community rather than entering an institutional setting. Savings achieved through an integrated financing model should be reinvested to expand the availability and quality of health care services and long-term care supports and services (LTSS). CMS and DHCS should require plans to collect and make available data measuring health outcomes, quality of care, consumer satisfaction and consumer complaints, and provide financial incentives to high-performing Demonstration sites.

5. Benefits:

The Demonstration model states that the sites will be responsible for providing enrollees with access to the full range of services to all Medicare C and D services and all State Plan benefits and services covered by Medi-Cal which includes the provision of long term care support sand services (LTSS).

The Center for Health Care Rights has direct experience with assisting dual eligibles obtain Medicare and Medi-Cal covered services within Medicare Advantage plans and Medi-Cal health plans. We frequently assist dual eligibles who are experiencing serious access to care problems because the plans or their contracting providers are not using Medicare and/or Medi-Cal guidelines to determine access to medical services. In addition, access to care problems frequently occur because decision making regarding access to medical services is delegated to the contracting IPA/medical group with little evidence of oversight by the plan.

Based on this experience, we ask DHCS to modify the demonstration model to require site plans to provide the following information:

1. How will sites insure the delivery of Medicare and Medi-Cal services if they delegate decision-making regarding access to services delegated to contracting IPA/medical groups? Will IPA/medical group denials be automatically reviewed by the site plan to insure that Medicare and Medi-Cal regulations and guidelines are being used to determine access to care?

2. With regard to providing access to Medi-Cal LTSS benefits, the site plans will work with IHSS, CBAS service providers, long term care facilities and MSSP providers to provide access to these services. Will the site plans primarily play a referral role to providing access to these services? What role, if any will site plan IPA contracting providers play in providing access to or coordinating these services?

3. Similarly, with regard to ensuring access to mental health and substance abuse services, what steps will the site plans take to insure that enrollees will obtain timely access to the most appropriate and mental health or substance abuse services, including those provided by County administered mental health agencies?

4. With regard to enrollee access to mental health, substance abuse and Medi-Cal LTSS, will site plans be required to take into consideration the enrollees past medical utilization in determining the appropriate linkage to needed services and maintaining continuity of care?

5. DHCS proposed to impose mandatory copayments on Medi-Cal beneficiaries. DHCS should clarify whether they intend for these copayments to apply to the Demonstration project. Because of the severe financial burden on dual eligibles, CHCR strongly opposes the imposition of any costsharing on beneficiaries enrolled in the Demonstration project outside of the appropriate Part D copayments.

6. Pharmacy Benefits:

The Demonstration model states that the sites will use Medicare Part D payment rules for pharmacy benefits. However, there is no discussion in the draft request regarding the coordination and provision of Medicare Part B or Medi-Cal pharmacy benefits. We ask DHCS to modify the draft document to provide explain whether Medicare Part B and Medi-Cal formulary, coverage guidelines and payment rules will also be integrated into the demonstration model.

In addition, CHCR strongly recommends that the Demonstration model continue to use the current Medi-Cal formulary without limitations due to the integration of the Medicare Part B and D benefits into the model.

7. IHSS:

The draft Demonstration model summary states that site plans will be required to use state law process to for the first year and contract with local social service agencies, but that in subsequent years demonstration sites may be able to expand their role.

We ask DHCS to provide clarification regarding what is meant by role expansion.

8. Behavioral Health:

The draft Demonstration model states that sites must have a plan for full integration of behavioral health services by Jan. 2015 using an integrated capitated model. The integrated model must include incentives that promote shared accountability for coordination and set performance objectives.

We ask DHCS to modify the draft document to include a discussion of the checks and balances that the sites will use to promote shared accountability for coordination and the delivery of services to enrollees.

In addition, we ask DHCS to modify the draft Demonstration model to address how local County administered Department of Mental Health programs will be integrated into the Demonstration project services.

9. Care Coordination:

The draft Demonstration model states that sites must demonstrate that they have the capacity to provide care coordination to meet the complex medical and behavioral health and long term care needs of dual eligibles.

Based on our experience with dual eligibles in Medicare Advantage plans, simple evidence that plans have systems in place for care coordination does not provide any information on how the plans will evaluate and monitor the effectiveness of their care coordination systems and identify enrollees who may get lost in the care coordination system.

We ask that this section of the Demonstration model be modified to require sites to provide more detailed descriptions of how their care coordination systems will be monitored and evaluated to assess the effectiveness of the care coordination system.

For example, sites might use enrollee data on use of emergency room services, inpatient hospital stays, Adult Protective Services referral, to identify higher risk enrollees who may need more intensive care coordination services.

10. Supplemental Benefits:

The Demonstration model encourages sites to offer additional benefits to enrollees such as transportation, vision and dental care. We ask DHCS to consider the following questions in better defining the definition, scope and cost sharing for these supplemental benefits:

1. Will sites be permitted to charge copayments for supplemental benefits? If yes, will DHCS place any restrictions on beneficiary cost sharing.

2. Are there any limitations on the types of benefits that a site can propose?

In addition, this section states that sites are encouraged to contract with community based services to provide supplemental benefits. Although CHCR strongly supports the use of community based services, sites should not propose the use of these services as an alternative to delivering needed Medi-Cal LTSS services to enrollees.

11. Technology:

The Demonstration sites that include such technologies in their models such as home telehealth technologies (i.e. daily health vitals monitoring, medication optimization, care consultations), remote monitoring of activities of daily living and safety technologies must have proper training for staff, as well as proper training for the patients.

12. Beneficiary Notification:

With regard to the approval of outreach and marketing materials, we ask DHCS to require consumer/advocate input into the review of these materials.

The Demonstration model states that alternative forms of communication with enrollees are required. We ask DHCS to more clearly define these alternative forms of communication.

Proper notification will require a minimum of three letters mailed out prior to the date of enrollment and three phone calls to the beneficiary to ensure proper notification. Materials must be mailed out in the appropriate language or Braille, and calls must be made to hearing impaired with use of video conferencing. There must be

clarification as to the agency responsible for the notification and who is responsible for fielding calls once notification begins.

In May 2011, the State of California rolled out a mandatory managed care program for Medi-Cal only patients. The notification process included two phone calls and three mailings. Since May, we have received many calls from Medi-cal beneficiaries with questions about their change in coverage. CHCR noticed the communication from the state that prompted the most calls to our agency was a short, one page notification. Given the beneficiaries' response to the mandatory managed care program notification process, we ask that the site plans include a minimum of three written notices, at least one of which is a short one page notice that briefly explains passive enrollment process. The one page notice must include a 1-800 number for beneficiaries to call with questions. The sites plans should also make a minimum of three phone calls to the beneficiaries. Additionally, there must be a properly staffed call center to field the phone calls after the notification is sent out.

Further, if the beneficiary notification is sent out late because of system errors or other issues, the beneficiary's enrollment should be delayed in conjunction with the time notification is mailed out to ensure that enrollment is always six months from the date the notification is mailed out. During the implementation of mandatory Medi-Cal managed care enrollment for the SPD population, CHCR encountered a number of affected beneficiaries who did not receive notices in a timely manner. Consequently, the beneficiaries were not afforded sufficient time to make a selection on their own and were instead defaulted into a plan.

Lastly, the Demonstration model states that the Part D marketing requirements apply. We also ask that the Demonstration model be modified to state that these marketing standards apply to Medicare Part C and D benefits.

13. Appeals:

The Demonstration model states that a uniform appeal process will apply across Medicare and Medi-Cal benefits and will use Medicare model standards. First, we ask that the DHCS modify the model language to explicitly state that the expedited appeals process available within Medicare Part C and D will be available.

Second, the Demonstration model must require strict response/decision time frames that are enforced. (i.e. a decision to a claim request must be made within 48 hours in emergent situations.) Third, the beneficiaries should be informed **prior to** enrollment about the appeal process. Specifically, the appeal process should be described in the materials that are mailed prior to their enrollment in the Demonstration.

Fourth, all denials from the site plan must include specific instructions on how to appeal in the decision, including any prescription drug denials. Specifically, in the event

of a prescription drug denial, instructions should be provided to the beneficiary at the point of sale. Further, we ask for clarification as to the agency that will be conducting the independent review.

Lastly, Medicare provides beneficiaries with a complaint process in which complaints can be filed against Medicare Part C and D providers by contacting the 1-800 Medicare hotline. This complaint process provides an important mechanism for beneficiaries to seek relief when the plan internal complaint and appeal processes are not working. Moreover, the complaints are tracked by CMS through the Complaint Tracking Module (CTM) system, which provides CMS with an independent source of data regarding beneficiary complaints and plan compliance with Medicare requirements. To continue with this type complaint tracking system, CHCR asks DHCS to allow for a beneficiary complaint system that will be part of this demonstration project.

14. Network Adequacy:

CHCR understands that DHCS intends to follow Medicare standards for network adequacy for medical services and prescriptions, Medi-Cal standards for LTSS, and an "exceptions process" for areas where Medicare network standards may not reflect the number of dual eligible beneficiaries. CHCR asks DHCS to provide a more detailed discussion of the exception process that is recommended and a more explicit description of the Medicare network standards. This must be made clear prior to implementation in 2013.

15. Monitoring and Evaluation:

Although this section of the demonstration model states that "all sites will be required to participate in an evaluation process organized by DHCS and CMS", CHCR asks DHCS to explicitly state how frequently the sites will be monitored. Additionally, DHCS must clarify what will be the impact on site services if monitoring and evaluation activities result in sanctions or corrective action plans for site plans.

Further, DHCS and CMS should involve the stakeholders in the monitoring and evaluation process. The beneficiaries should be given written notification about how to file a complaint. Additionally, the repercussions for egregious violations committed by site plans should include plan suspension, fine and or termination of contract.

16. Quality Incentives:

The Demonstration model states that participating sites will not be eligible for Medicare star bonuses but will be subject to an increasing quality withhold.
We ask DHCS to clarify if the quality withhold is based on a Medicare Advantage quality incentive measure or on a state measure. In addition, we ask that quality incentives

that are used in this Demonstration project should incorporate consideration data on member satisfaction, the number of appeals filed by members and the number of complaints filed by members.

Additionally, we ask DHCS to clarify the measure used to determine quality care and also, who is monitoring the quality of the site plans.

17. Medical Loss Ratio:

The Demonstration model states that no minimum medical loss ratio is required. CHCR strongly recommends that DHCS adopt Medicare's Medicare Advantage plan requirement that plans must meet an 85% medical loss ratio.

18. Ongoing Stakeholder Involvement:

CHCR strongly supports DHCS's requirement of meaningful involvement of external stakeholders, including consumers, in the development and ongoing operations of the program will be required. This should include regularly scheduled meetings and also more transparency into the operations of the site program, including site performance and timely access to the information.

CHCR also asks that consumers , advocates and other stakeholders also have access to information on site performance that is gathered by DHCS.

II. Selection of Demonstration Sites:

1. Qualifications:

Successful applicants for Demonstration sites should demonstrate the following experience:

1) Include a Medicare SNP plan with a Medicare star rating of 3.5+ or better. In addition, this SNP plan should have no record of Medicare non-compliance, sanctions, corrective action plans or other evidence of poor plan performance in the last 3 years.

2) All site plans should have strong HEDIS performance results.

3) NCOA or Medi-Cal plan accreditation.

4) Include plans that have strong performance track record as a Medi-Cal contractor.

5) Include the use of provider networks, medical groups, and IPAs that have no evidence of poor performance.

2. Current Medi-Cal Mangaged Care Plan:

CHCR recommends that applicants must have a current contract with DHCS to operate a Medi-cal Managed Care contract in the same county in CA as the proposed dual eligible site.

3. Integrity:

Any applicant that has had sanctions or penalties taken by Medicare or a California agency in the last three years should not qualify as an applicant.

CHCR asks DHCS to state in the request what impact Medicare sanctions or penalties will have on a demonstration site's eligibility to participate in the program.

4. County Support:

Letters of agreement should state clearly the working relationship between the county agency and the applicant. Evidence of contracts or formal agreements will provide stronger evidence of collaboration.

5. Stakeholder Involvement:

Successful site applicants must certify that they meet all of the stakeholder involvement criteria as outlined in the demonstration model.

6. Selection Methodology:

CHCR also asks DHCS to clearly state how the project application for each site will be graded and scored using a point system or other scoring methodology.

We thank you for the opportunity to submit comments the Draft RFS. We look forward to working with you to ensure that the Medicare and Medi-Cal programs provide high quality care and services to older adults and people with disabilities.

Sincerely,

Aileen Harper	Stephanie Lee	Bridget Homer
Executive Director	Staff Attorney	Staff Attorney

520 So. Lafayette Park Place, Suite 214, Los Angeles, CA 90057
213/383-4519, 800/824-0780, Fax: 213/383-4598

California Foundation for Independent Living Centers

Chair
Sheri Burns
Community Resources for Independent Living
Hayward

Vice Chair
Dolores Kollmer
Dayle McIntosh Center
Garden Grove

Member at Large
Yomi Wrong
Center for Independent Living, Inc.
Berkeley

Treasurer
Robert Hand
Resources for Independence Central Valley
Fresno

Secretary
Sarah Triano
Silicon Valley Independent Living Center
San Jose

Development Chair
Eli Gelardin
Marin Center for Independent Living
Marin

State Independent Living Council Representative
Louis Frick
Access to Independence
San Diego

Immediate Past Chair
Elsa Quezada
Central Coast Center for Independent Living
Salinas

FREED Nevada City
PIRS Auburn
DSLC Santa Rosa
ILR Concord
ILRC San Francisco
CID San Mateo
ILRC Santa Barbara
ILCKC Bakersfield
WCIL Los Angeles
CALIF Central Los Angeles
CRS East Los Angeles
DRC Long Beach
SCRS Downey
SCIL Claremont
RSI San Bernardino
CAC Riverside

Teresa Favuzzi
Executive Director

1234 H Street, Suite 100
Sacramento, CA 95814
(916) 325-1690
(916) 325-1695 TDD
(916) 325-1699 FAX

www.cfilc.org

January 9, 2012

Toby Douglas, Director
California Department of Health Care Services
1501 Capitol Mall
P.O. Box 997413
Sacramento, CA 95899-7413

RE: Dual Eligible Demonstration Request for Solutions

Dear Director Douglas,

The California Foundation for Independent Living Centers (CFILC), based in Sacramento, is a statewide, non-profit organization representing 24 Independent Living Centers (ILCs). ILCs provide direct services to people with disabilities of all ages, assisting them to lead successful lives in communities throughout the state. CFILC's mission is to support the work of ILCs through advocating for systems change and promoting access and integration for all people with disabilities.

The purpose of this letter is to offer our comments and suggestions on the Request for Solutions (RFS) for California's Dual Eligible Demonstration.

We have actively participated in the stakeholder process for the demonstration and have given ongoing feedback as the State has developed the project. We believe, as the State has also articulated, that a person-centered, integrated system of care is in the best interests of California's seniors and people with disabilities and that such a system could be more cost-effective while at the same time assisting the State to move forward in its implementation of the Supreme Court's Olmstead decision.

We are, however, disappointed in the RFS. We do not feel that it accurately reflects the feedback that we have provided; nor, as

it is currently conceived, that it represents progress or good policy for California's vulnerable dual eligible population.

These are some of our chief concerns about the RFS and our suggestions to address them:

1) **Exemption of People Who Have Been Institutionalized for Longer than 90 Days** (Demonstration Model Summary: Key Attributes, Demonstration Population, p. 9). In this section the State poses the question, *"DHCS is seeking comments on this entire document and in particular on whether the Demonstration should exclude beneficiaries…Who have been institutionalized for longer than 90 days."*

   That the State should pose this question gives us great concern. To the best of our knowledge, such an exemption was not discussed in stakeholder meetings nor documented as a decision point in distributed materials during the development phase. It is a complete surprise that the State is contemplating this idea. It is contrary to feedback that we (and many other stakeholders) have provided. Furthermore, we do not understand the policy rationale for such an exemption; it is out of step with best practices for long-term services and supports to ignore the desires of people who wish to move from institutional settings to the community. We believe that it is contrary to the requirements of the Olmstead decision.

   Such an exemption would also be costly to the State. A few examples: the state of Texas has transferred over 25,000 people from nursing facilities to home and community-based services (HCBS), resulting in a $2.6 billion savings between 1999-2007 (Texas Legislative Budget Board, 2009). Pennsylvania is a smaller state with a similar experience – for the past three and a half years, the state has transferred 1,600 people each year from nursing facilities to HCBS, contributing to an estimated drop of 2,000,000 in the number of Medicaid days and saving the state an estimated $200 million in nursing facility expenditures (State staffs, Pennsylvania Department of Aging, Office of Long-Term Living, personal communication, 9-22-11). The state of Tennessee has historically been one which provided very few HCBS, however, in launching its 2008 Long-term Care Community Choices Act, the state made intentional policies to incentivize HCBS in

multiple ways within its managed care program. As a result of these policies, the state is now seeing an average of 1% rebalancing away from nursing facility utilization *each month* (State staffs, Tennessee Long-term Care Strategic Planning and Program Implementation, Bureau of TennCare, personal communication, 11-22-11). California should be just as intentional in reducing nursing facility utilization in the dual eligible demonstration.

CFILC is strongly opposed to exempting persons who have been institutionalized for 90 days, or any period of time, from the dual eligible demonstration. We recommend that transition services, including services to assist in securing housing and transportation, and an allowance for flexible relocation expenses, be developed as core services within all plans. These mechanisms are utilized in a number of state managed LTSS systems and California should develop them as well.

2) **"Lock-in" Enrollment for Six Months** (Demonstration Model Summary: Key Attributes, Enrollment, p. 9). In this section the State indicates that beneficiaries would be automatically enrolled into the Demonstration and signals its willingness to approach the Centers for Medicare and Medicaid Services to ask for a so-called 'lock-in': *"Under passive enrollment, beneficiaries will be able to opt-out of the Demonstration and choose from their care delivery options as available in that county. Applicants also should explain whether they would pursue an enrollment lock-in up to six months – an approach that would require the state to seek special permission from the Federal government."*

Throughout the process, we have expressed a preference for affirmative choice to enroll in one of the plans being offered under the demonstration. The State signaled clearly that it would be proposing passive enrollment; however, the counter to our concern was the promise that individuals would have the option to "opt-out." We are again surprised by this enrollment "lock-in" proposal, which ignores a vast amount of stakeholder input. The most important consumer protection is the ability to leave a plan that is not effectively addressing a consumer's needs. Furthermore, we believe that the State should be signaling high expectations to the plans; demonstrating that they will be expected to deliver high-quality, innovative

care and that they should expect to have to compete for both the State's and the individual consumer's business. The six-month "lock-in" provision sets a very low expectation from the outset and directly undermines the incentive to provide high-quality care. We believe that financial sustainability of the plans should be provided by other means, such as a risk corridor where the state and the plans share both risk and profit beyond a certain point, and through means of a blended rate with risk for nursing home utilization, where plans benefit financially if current nursing facility utilization is lower than the historical experience used to set the rate.

We recommend that the state should in fact strengthen consumer choice by providing options counseling about the services available, and recommend that Programs of All-Inclusive Care for the Elderly (PACE) should be included in all enrollment materials and outreach efforts so that beneficiaries are fully aware of it and are able to directly enroll in PACE. Beneficiaries who are enrolled in plans who become eligible for PACE should also have the option to disenroll and enroll in PACE at that point.

CFILC strongly opposes any proposals for a six-month enrollment "lock-in" and recommends options counseling to support choice, as well as the full opportunity for all eligible beneficiaries to enroll in PACE.

3) **Up-front savings for Both Medicare and Medicaid** (Demonstration Model Summary: Key Attributes, Integrated Financing, p. 10). In this section the State provides a very brief description of the integrated financing model, including the expectation of first-year savings: *"The rate will provide will provide (sic) upfront savings to both Medicare and Medicaid."*

We are concerned that the State is assuming savings with the very brief level of planning and detail that has been provided. While we support a blended capitation rate with risk for utilization of services (including institutional services), no detail has been provided to stakeholders about the financing models that would demonstrate that there will be enough money in the system for high quality and enhanced services along with year one savings. The models are too new, the capacity unclear, the experience with managed long-term services and supports (MLTSS) too untried, to

justify this assumption. If the State and the health plans do not make strategic investments into expanding HCBS, the potential for long-term savings is greatly reduced; therefore, we urge that funding should be left in the system at the current level during the first year, and estimated savings should be held off until year two, and then should be based on analysis and evaluation in an appropriate justification.

We are also very interested in understanding the details of the financing models, especially in the incentives that will encourage high quality services, provision of HCBS, and control inappropriate utilization of institutional services. We are uneasy that these projects are proceeding on a fast-track without this information being thoroughly and transparently considered.

CFILC opposes taking upfront savings to Medicare and Medicaid in year one, based on the uncertainties of the new model and the vulnerability of the population, and seeks more information about the financing model.

4) **Person-Centered, Independent Assessment** (We are concerned that this essential consideration is addressed only in passing within the RFS).

Person-centered assessment, which in our view should be central to the dual eligible demonstration, receives scant attention in the RFS, being a matter left to the plans (*"Describe how you would use your Health Risk Assessment Screening to identify enrollees in need of medical care and LTSS and how you would standardize and consolidate the numerous assessment tools currently used for specific medical care and LTSS"* p. 25). The neglect of this central issue is a serious flaw of the RFS. We believe that the State should re-think the central role of assessment in care planning, strengthen the assessment processes, and design a system of independent assessment to that provides access to the services delivered by the health plans.

AARP California has put forth a recommendation that the State consider the Personal Experience Outcomes – Integrated Interview and Evaluation System (see http://chsra.wisc.edu/peonies) used in Wisconsin. This assessment focuses on the desires of consumers and creates a plan of care

based on the consumer's experience and creates a credible basis for LTSS evaluation and care planning. We strongly concur with this suggestion.

Furthermore, we believe that it is a best practice that the entity which is financially responsible for delivering services is not the entity tasked with assessing the need for services, and as such, the state should develop a system for independent assessment of consumer needs. New Jersey has tasked Aging and Disability Resource Centers (ADRCs) with providing independent assessment for MLTSS, and we believe that this it is worthwhile to explore ADRCs as a disinterested, independent "single point of entry" and assessment for the dual eligible demonstration. In areas of the state where an ADRC is not yet established, other existing community agencies with a similar function could take the lead on conducting an independent, person-centered assessment process, that health plans would use as the basis to formulate a plan of care.

CFILC supports the use of an independent and person-centered assessment process in the dual eligible demonstration, and recommends the Wisconsin Personal Experience Outcomes – Integrated Interview and Evaluation System as a model. We also recommend ADRCs as a centralized, single point of entry to services that could conduct an independent MTLSS assessment process.

5) **Housing** (We are concerned that this essential consideration is not addressed within the RFS).

We have on numerous occasions raised the central issue of the lack of affordable housing options as a key factor in inappropriate institutionalization, as well as the importance of policies such as home modification and home upkeep allowance that allow people to retain their current housing when a health crisis impacts their living situation. It is a disappointing that we do not see this addressed in the RFS, and we question the State's central assumption that it can create cost-savings without understanding the critical role of proactive housing policies in reducing inappropriate institutionalization.

States that have made strides in reducing inappropriate institutionalization have created housing policies that California should note: see a description of Pennsylvania's multi-faceted housing policies to support community-living here: http://tinyurl.com/7jotjq8 (18. Mildred PA Handout). Housing strategies can also be created within managed care systems: for example, Tennessee includes home modification, assistance securing housing and pest control services within its array of MTLSS, in order to assist individuals to secure and keep housing and prevent inappropriate and costly institutionalization.

CFILC supports a full range of housing policies inside and outside of the dual eligible demonstration that support individuals to find and keep housing so that they do not need to rely on costly institutions for housing options.

6) **IHSS** (Demonstration Model Summary: Key Attributes, IHSS, p. 11). In this section the State provides for only a year one plan for the integration of IHSS into the demonstration: *"In the first year of the Demonstration, IHSS benefits will be authorized under the same process used under current state law. The Demonstration site will contract with the County social service agency. Sites must work with Counties to develop processes that allow information sharing on the care needs of the clients. In the subsequent years, the Demonstration site can suggest expanding its role."*

We believe that with regard to the IHSS program, the state's most important HCBS program and a key strength of the long-term services and supports system, the level of planning and detail offered in the RFS is wholly inadequate. The State should not expect to make wholesale changes to the IHSS program on the strength of one paragraph of placeholder language. We believe that the State should endeavor to negotiate and present a detailed plan for the IHSS program's integration into the dual eligible project on an ongoing basis for future years.

Most importantly, we are concerned that the consumer direction of the IHSS program is seen by the State as an additional program detail that can be worked out in the future. This is unacceptable. We assert that

consumers should continue under the dual eligible demonstration to have the rights to hire, fire, schedule and supervise their personal care services providers, and should continue to have the option to hire family members to perform these services. These consumer protections should be explicitly delineated in the RFS, and should be protected in perpetuity as the ongoing basis of California's strong and successful personal care services. The consumer direction of personal care services cannot be compromised, whatever the service delivery model that California adopts.

CFILC supports the development of further detail and negotiated out-year plans for IHSS program administration. Furthermore, we strongly oppose any and all proposals that do not preserve the consumer direction of personal care services as a foundational concept and that explicitly protect and preserve that principle into the future. Consumer direction must be an explicit pillar of the demonstration; it cannot be deferred to be negotiated in the future.

7) **Behavioral Health** (Demonstration Model Summary: Key Attributes, Behavioral Health, p. 11). In this section the State primarily addresses the fiscal and system organization of behavioral health integration: *"Demonstration sites are required to have a plan to achieve full integration of behavioral health services by Janary 1, 2015 (i.e. inclusion of behavioral health services into the integrated capitated payment). For enrollees with serious mental illness who currently receive services through the County Speciality Mental Health System, formal partnership agreements between Demonstration sites and Counties will be required. Phased approaches will be acceptable, but should include incentives that promote shared accountability for coordination and achieving set performance objectives."*

In principle, while we find that 2015 is a very long timeframe to wait for full integration of behavioral health, we do not object per se to a phased approach. We do believe that specific focus should be given to the needs of any dual eligible persons residing in state hospitals or skilled nursing facilities designated as Institutions for Mental Disease, and that those persons should be served by the project in year one.

We are troubled however that more attention appears to have been focused on the problem of integrating the system, and no attention has been given to the integration of behavioral health for the person. Discussion with demonstration planning project staff revealed no consciousness of the major gaps in mental health services in California, the unserved needs of racial, ethnic and linguistic minorities, of older adults, especially those with dementia, of persons with physical disabilities, and the underserved needs of persons who are currently served by the mental health system.

It is the State's responsibility to fully understand these gaps in services and to design a fully integrated approach to behavioral health care *from the inception of the project,* so that all participants receive the level of behavioral health services that they are entitled to, regardless of how long the fiscal or administrative phasing may last. This is another strong argument against taking Medicare and Medicaid cost-savings up front; there are huge unmet behavioral health needs for the dual eligible population, and appropriate planning, financing, services, monitoring, evaluation and oversight will be needed to fulfill the State's responsibilities.

CFILC believes that the State has given inadequate attention to the integration and provision of integrated behavioral health services under the RFS, and that it needs give formulate a clear plan for meeting its responsibilities to fully address these needs from year one of the demonstration. The plan should include an analysis of the population's behavioral health needs, disparities, gaps in services, a detailed array of services to be offered and financing to adequately address identified needs.

8) **Disability Access** (Application Submission; Selection of Demonstration Sites, Qualification Requirements, 9. Americans with Disabilities Act and Alternate Format, p. 21). In this section the State creates a requirement for disability access: *"Applicants must certify that they shall fully comply with the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973 in all areas of service provision, including communicating information in alternate formats, and shall develop a plan to encourage its contracted*

providers to do the same. The Applicant must further certify that it will provide an operational approach to accomplish this as part of the Readiness Review."

We agree with the State's emphasis on disability accessibility within the demonstration. This will be especially critical to the population of dual eligible individuals. We believe that these provisions should be further specified and strengthened:

A) *"Applicants must certify that they shall fully comply with* all state and federal disability accessibility and civil rights laws, including but not limited to *the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973 in all areas of service provision, including communicating information in alternate formats, and shall ~~develop a plan to encourage~~ require its contracted providers to do the same. The Applicant must further certify that it will provide an operational approach to accomplish this as part of the Readiness Review."*

B) Provide Specifics:

The State requires that the plan's medical and related buildings and facilities are architecturally accessible to people with disabilities in compliance accordance with Federal and state standards. The State must also require the plans to assess their full provider network for compliance with these physical accessibility standards.

Plans and providers must adopt policies and procedures for programmatic accessibility to effectively communicate and to provide necessary medical information and directions in accessible formats, including the use of sign language interpreters wherever needed. Medical staff and others that interact with these beneficiaries must complete staff training programs on how to identify and assist individuals who may have programmatic accessibility needs, how to interact with disabled persons with language or communication limitations, and meet linguistic and cultural competency standards.

C) Specify Enforcement:

All plans should be required to meet explicit network standards for primary and specialty care and other critical professional, allied health, supportive services, and medical equipment that are above the existing state standards for primary care providers.

Prior to being authorized to participate, each plan must demonstrate its capacity to provide non-disrupted and appropriate health care to seniors and people with disabilities. County-based plans must also demonstrate that capacity to serve and must have policies and procedures in place for appropriate care prior to any enrollments.

The state should utilize all state agencies with legal jurisdiction to monitor, assess, and report on the progress of the transition and implementation of the mandatory managed care program. These include, but need not be limited to, the California Department of Managed Care, the Office of Statewide Health Planning and Enforcement, and the Safety Net Financing Division of the Department of Health Care Services.

CFILC recommends that several specified measures be adopted to strengthen the disability access provisions of the demonstration, and that enforcement should be added to ensure compliance. We also recommend that performance measures should also be utilized to ensure accessibility (see Recommendation 9, below).

9) **Quality Incentives** (Demonstration Model Summary: Key Attributes, Quality Incentives, p. 12). In this section the State specifies an approach to quality incentives: *"Participating sites will not be eligible for Medicare star bonuses. Plans will be subject to an increasing quality withhold (1,2,3 percent in years 1,2 and 3 of the Demonstration). Sites will be able to earn back the capitation revenue if they meet quality objectives."*

States with established MLTSS systems go further, establishing performance measures that support quality. For example, Tennessee has strict performance measures with associated liquidated damage penalties

for missing service timeline requirements for sentinel events, such as enrollment in HCBS, assessment, services planning and commencement of services. Arizona has similar performance measures to reinforce timelines for service delivery. Texas requires their managed LTSS plans to develop a long-term services plan within 30 days for new enrollees. California would benefit from such standards.

In addition, we have received widespread reports that physical and programmatic disability access requirements are not being adhered to within the State's transition of seniors and persons with disabilities to managed care through the 1115 waiver. Full compliance with all state and federal disability accessibility and civil rights laws, including but not limited to the Americans with Disabilities Act and Section 504 of the Rehabilitation Act, should also be included in the plan performance measures, with penalties assigned for failure to comply.

CFILC supports the development of performance measures requiring service timelines for sentinel events to reinforce quality and performance, including full compliance with all state and federal disability access and civil rights laws.

CFILC remains ready to assist the State in developing an integrated system for the dual eligible demonstration that is high in quality, person-centered and utilizes public dollars in the most effective manner. We believe that attention to these issues will enhance that effort.

If you would like more detailed information about any of this information, please feel free to contact Laurel Mildred, MSW, laurel@cfilc.org or 916-862-4903.

Sincerely,

Teresa Favuzzi, MSW
Executive Director

Community
Health Group

January 9, 2012 Send Via Email

Toby Douglas
Director
Department of Health Care Services
1501 Capitol Avenue, MS 000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Douglas:

Community Health Group would like to thank you for the opportunity to submit comments on the Request for Solutions (RFS) for California's Dual Eligibles Demonstration Project.

The RFS requires responses to areas of new risk that many managed care plans currently do not provide. The new areas of risk include but are not limited to in home services and long term care. The development of responses to items in the RFS that cover the new areas of risk will need to be both responsive and realistic and should be based upon the knowledge of the estimated total capitation payment that will ultimately be received to provide the services included in the RFS. Therefore, it is strongly recommended that an estimate or an estimated range of the capitated payment be provided to the health plans to be used in developing realistic responses to the RFS.

Thank you again for the opportunity to provide comments to the Department on this very important project.

Sincerely,

Bill Rice
Chief Financial Officer

cc: Norma Diaz, CEO

740 Bay Boulevard, Chula Vista, CA 91910 · Phone: (619) 422-0422 · FAX: (619) 422-5930

Attn: Toby Douglas, Director

RE: Responding to the request for comments on the draft RFS for California Dual Eligibles Demonstration Project

There are two requirements in the Draft CA Dual Eligible Demonstration Request for Solutions that are problematic.

3.a Two Plan Model Counties: At least one of the Applicants must operate a D-SNP in good standing with Medicare

This requirement disadvantages Two Plan counties in which neither has a current SNP.

CCHP has participated for 28 years in Medicare Cost and managed a Dual SNP for 5 years until 1/1/12. CCHP discontinued our SNP as of 1/1/12 due to CMS decreases in rates and the refusal to allow small plans the option to participate in the star ratings due to size. CCHP more than meets the SNP requirements and with passive enrollment, membership size would no longer be a factor. We are willing to pursue a 3 way contract with CMS, DHCS and us, even if Blue Cross is not.

4.a Two Plan Model Counties: For Applicants in Two Plan Model Counties, applications will only be considered if both plans submit an individual application.

CCHP has a long history of working with IHSS, ADHC, the Area Agency on Aging, and community agencies such as Meals on Wheels and has planned together with these entities to implement this Dual Pilot.

This requirement in Two Plan Counties to force competitors to both participate in the Dual Project, once again disadvantages CCHP and other Two Plan Counties where the LI has a lengthy history of collaboration with home and community service agencies and the indemnity plan has none.

The real issue of patient choice is still one of allowing for a FFS option in a Two Plan County. Duals are not mandated into choosing this pilot. Passive enrollment with opt-out will still allow duals to remain on Medicare FFS and Medi-Cal FFS even if the indemnity provider does not choose to participate in this pilot.

Patricia Tanquary, MPH, PhD
Chief Executive Officer
Contra Costa Health Plan
595 Center Avenue, Suite 100
Martinez, CA 94553

January 10, 2012

DHCS Procurement Office
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413
Transmitted by Email: OMCPRFP9@dhcs.ca.gov

RE: Draft Request for Solutions – California's Dual Eligible Demonstration

Dear DHCS staff & Harbage Consulting:

As you know, the counties and Public Authorities have been working together to coordinate input and develop joint recommendations for the Dual Integration Demonstration projects. The Governor's new state budget proposals on mandatory managed care, dual integration, IHSS and Phase II realignment add significant complexity to the challenges associated dual integration. Counties and Public Authorities are prepared to work in partnership with the state to reasonably implement current law that specifically authorizes pilot projects for integration of services to dual eligibles in four counties. It is premature to expand the number of pilots from four to ten counties while simultaneously implementing a statewide mandatory Medi-Cal managed care system over the next three years. We believe various models should be tested before deciding on a statewide change that would affect the 1.2 million dual eligible beneficiaries and all IHSS consumers in California. Notwithstanding our concerns about the Governor's new state budget proposals, Welfare and Institutions Code 14132.275 clearly requires the state to establish dual integration pilot projects in up to four counties. Our questions and comments about the Governor's new budget proposals will be addressed separately and over the course of the budget process. Accordingly, we offer the following comments to the Request for Solutions that are exclusively focused on developing pilot projects in four counties to preserve and enhance home-and-community based services to seniors and people with disabilities.

Our comments reflect page numbers from the draft RFS released in the regular font size and, therefore, the page numbers will not track with sections in the large font version. Following are our specific comments:

Page 4 – Authority

- This section should clearly state that that the pilots must comply with existing state law or regulations. We believe this is essential to differentiate between the four pilots authorized under current law and the budget proposals related to dual integration and managed care that were released by Governor Brown on January 5, 2012.
- This section only refers to CMS's interest in testing "capitated payment models" and should be expanded to reflect the second model authorized by CMS to test fee-for-service approaches to integration. The final site selection criteria should allow integrating entities to submit applications that test both capitated and fee-for-service models.

Page 4 – Background

- The draft says there are 1.1 million dual people enrolled in both Medicare and Medical in California and the A-pages of the budget proposal says there are 1.2 million dual beneficiaries. Please clarify which number is correct.

Page 5 – Additional Comments on the Background section

- The last paragraph should be deleted. While the administration may want to expand the number of counties to integrate services for dual beneficiaries, current law only authorizes pilots in four counties. The administration's proposal to expand the number of counties should be discussed through the legislative and state budget process, and should not be intertwined into the RFS that is limited to the provisions enacted in SB 208.

Page 6 – Demonstration Goals

- We agree with the goals listed for the demonstration, particularly those related to expanding access to home and community based services and preserving and enhancing self-direction. An additional goal should be added to minimize disruption of care for beneficiaries who are enrolled in the dual integration projects and to improve the quality of care provided to dual eligible. For all the goals, the Department needs to explain in this document or others how progress towards each goal will be measured.

Page 7 – Demonstration Population

- The document uses contradictory terms about the target population. This section states, "All full benefit dual eligibles in the selected Demonstration **areas** will be eligible for enrollment." On page eight, under "Geographic Coverage" the document states, "To be considered for the Demonstration, potential sites must be capable of covering the entire county's population of dual eligibles. SB 208 does <u>not</u> mandate the pilot projects to cover 100% of the eligible population of dual beneficiaries. In

fact, Welfare and Institutions Code 14132.275 (c) specifically authorizes DHCS to implement the pilot projects in phases. We think the RFS should delete the requirement for project sites to cover all of a county's dual eligible so applicants can create and DHCS can test different models with high quality standards.

- Under the paragraph that says "Note:…" this language is not sufficiently clear about the carve-out of individuals receiving care under the Home and Community Based Services Waiver for the Developmentally Disabled (HCBS-DD).
- Carve-outs & Exclusions – we strongly recommend that DHCS delete the language to exclude beneficiaries with specific chronic conditions as well as the exclusion of dual beneficiaries who have been institutionalized for more than 90 days. These crave-outs are discriminatory, create disincentives about developing efforts to move people out of institutional care, violate the Americans with Disabilities Act and *Olmstead* decision, and would allow integrating entities to cherry-pick out the most expensive cases to protect their financial bottom-line.
- Clarification is needed about whether beneficiaries who have a share-of-cost are included in the pilot projects.

Page 8 – Enrollment

- We oppose passive enrollment and prefer voluntary enrollment as previously conveyed in comments submitted to DHCS. Voluntary, "opt in" enrollment processes have been used by integration models that are generally regarded as positive, beneficiary-centered programs. For example, the Program for All-Inclusive Care for the Elderly (PACE) is an "opt in" model. Massachusetts' Senior Care Options, Minnesota's Senior Health Options and Wisconsin's Family Care Partnerships all use an "opt in" enrollment model.
- Likewise, we are strongly opposed to the suggested six-month lock-in. The recent experience with passive enrollment in the state's transition plan for ADHC is revealing. In August, a letter and application packet went out to about 26,000 people in the adult day health care system, a program slated for elimination as a Medi-Cal benefit on December 1, 2011. Beneficiaries were asked to choose between three options: They could sign up for one of the managed care options; they could send in a form to opt out of those plans; or they could do nothing, and would be automatically enrolled. Of those 26,068 patients, 654 chose a managed care plan, and another 10,297 people did nothing and were automatically enrolled in a managed care plan. The majority -- 15,117 people -- chose to remain in their fee-for-service plans.
- At a minimum, the DHCS should test both passive and voluntary enrollment.
- If mandatory enrollment is required, DHCS should establish exceptions if the beneficiary has a chronic medical condition that is being treated by a specialist physician who is not a part of the managed care network or good cause for not wanting to enroll.

Page 8 – 3rd paragraph on PACE

- Additional language is needed to inform beneficiaries about options to receive services through PACE. We think information about PACE should be included in all enrollment materials and outreach efforts so that beneficiaries are fully aware of it and are able to directly enroll in it, and that beneficiaries who are enrolled in plans who become eligible for PACE should have the option to disenroll and enroll in PACE at that point.

Page 8 – Integrated Financing

- We are extremely concerned by the lack of information about how Demonstration plans will be financed. It is critical to not disrupt the current 1991 Realignment structure to prevent unwanted Proposition 98 challenges that, if successful, could cause the unintended consequence to shift funds away from current health, mental health and social service programs. In its call on January 5, when asked by a plan representative whether plans would be bound by their responses to the RFS in light of the fact that rates have not yet been established, the response was that neither plans nor DHCS would be bound until final contracts were negotiated and signed. The lack of guidance on funding for the demonstration projects as well as the rates to be paid to integrating entities makes it extremely difficult for plans to realistically propose what services they could offer and even more difficult for stakeholders and DHCS to compare proposals since there is no guarantee that responses to the RFS will in any way correspond with the final package of services that any applicant can or is willing to offer.
- This section only refers to CMS's interest in testing "capitated payment models" and should be expanded to reflect the second model authorized by CMS to test fee-for-service approaches to integration. The final site selection criteria should allow integrating entities to submit applications that test both capitated and fee-for-service models.
- We are concerned about the statement that, "The rate will provide upfront savings to both Medicare and Medicaid." It should be recognized that savings are unlikely to be quickly achieved and that high quality systems are essential to avoid preventable hospitalizations and nursing home placement. Better primary and preventive care can, likewise, produce long-term savings. The heavy emphasis on upfront savings implies that service reductions are likely to be imposed by the integrating entities on beneficiary services. Therefore, this sentence should be deleted.

Page 8 – Benefits

- Clarification should be added that Demonstration sites must provide seamless access to benefits but may do so utilizing a range of models that include coordination with existing agencies providing such services to integration under the Duals demonstration.

Page 9 – IHSS

- We are extremely concerned the draft RFS requires Demonstration sites to contract with County social service agencies for only one year rather than for the full three years of the demonstration and fails to require a separate contract with the local Public Authority (see additional comments below). Demonstration sites do not have any experience in administering the IHSS program. This draft RFS would allow Demonstration sites to suggest an expanded role without identifying the criteria that would ensure Demonstration sites are capable of such an expanded role, nor does it describe the criteria to allow for such an expanded role that ensures adequate protections to IHSS consumers. One year is an extremely short and inadequate amount of time to ensure that Demonstration sites are capable of meeting the unique and diverse needs of IHSS consumers. Nor is it an adequate amount of time to allow Demonstration sites, working in partnership with counties and Public Authorities, to realize care and service improvements for IHSS consumers. Also starting in 2014, an additional two million individuals will become eligible for the Medi-Cal program which will result in greater demands on the health care service delivery system at the very time the department proposes to allow Demonstration sites to assume greater responsibility in the administration of the IHSS program.
- The RFS allows Demonstration sites to expand its role but lacks details in what way the sites may expand. Would the role of the County IHSS or the local Public Authority change and in what way? Or would IHSS services potentially change, and if so, in what way? It is unclear how the County IHSS or Public Authority roles would change, and how this would fit with existing IHSS statutes and regulations which require counties to perform assessments and other IHSS functions. The RFS is completely deficient in this section and doesn't even reference Public Authorities.
- We recommend the Demonstration sites must contract with the County social services agency for a minimum of three years (or during the course of the demonstration). During the three years, the sites may contract and purchase different models of IHSS case management and service delivery so long as it conforms to existing IHSS statute and regulations, including tiered case management based on the individual needs of IHSS consumers served under the Duals demonstration. (note: refer to our comments on page 9-Care Coordination and pages 23/24-IHSS for additional suggestions).
- Likewise, we recommend that the demonstration sites be required to establish a separate contract with the local Public Authority. Welfare and Institutions Code 14132.275 (g) specifically requires demonstrations projects to provide IHSS through "direct hiring of personnel, contract, or establishment of a public authority or nonprofit consortium, in accordance with, and subject to, the requirements of Section 12302 or 12301.6, as applicable." WIC 12301.6 is the code section that establishes the authorities, functions and mandates of local Public Authorities. In compliance

with state law, the RFS should clearly require integrating entities to contract with the local Public Authority for the duration of the demonstration project.

- The RFS should be revised to require demonstration sites to comply with existing consumer rights and protections, including their ability to select, hire, fire, schedule and supervise their IHSS provider (including the right to have family members serve as their provider) through the duration of the demonstration projects and not leave it to the health plans to describe what they want to do in years 2 and 3.
- We are assuming that current law will govern financing of the pilot projects, which means that counties would financially participate in IHSS services. The simple fact that county dollars will be used in the capitated rate underscores the necessity to have contracts in place between counties and integrating entities for the entire period of the demonstration project, not just in Year 1.
- We support the concept of shared information between the sites and counties; however, we note that given current IHSS state laws and regulations that additional support may be needed from the State to facilitate information exchange.

Page 9 – Care Coordination

- It is disappointing that the RFS contains so little detail about what will be expected from the integrating entities for care coordination. The entire theory that is being tested by the dual demonstration projects is that strong care coordination and case management will lead to better care at a lower cost. We support person-centered care coordination and think the RFS should require demonstration sites to include the consumer in the development of their care plan with the care coordination team. The RFS should also require consumers to decide whether their IHSS provider would participate in the care coordination team. CSAC-CWDA-CAPA provided the following suggestions in our December 14, 2011 letter to DHCS Director Douglas and CDSS Director Lightbourne:

    - Under the Duals Demonstration, Health Plans should have three options in contracting with counties. These three options represent increasing levels of coordination with county programs, and allows Integrating Entities to leverage existing local infrastructures where they exist in many counties (for example: counties where program and services such as Area Agency on Aging, MSSP and IHSS are jointly administered by the County):
    - Option 1: At a minimum, Health Plans will contract with IHSS county programs for referrals, intake, assessments and authorization of IHSS services. Contracted IHSS staff would provide additional case management services for IHSS clients who receive care coordination through the Integrating Entity. IHSS social workers will also participate in care coordination efforts of IHSS consumers participating in the Duals Demonstration.

- Option 2: Health Plans could contract to have county staff act as care coordinators, who would be able to simultaneously authorize IHSS services and conduct a comprehensive intake/assessment of the consumer's needs and link to necessary services funded through the Health Plan and to other community-based care options. County care coordinators, working with the Health Plan, could target and better serve consumers based on acuity and multiple needs. One option for care coordinators is to utilize specialty-trained social worker staff or, as many counties have done, Public Health Nursing staff as care coordinators. One benefit in using Public Health Nursing staff is the higher draw down of federal Medicaid matching dollars for case management, and their training in the health field. County care coordinators can link consumers to services offered by Health Plans as well as leverage community resources including county behavioral health programs, transportation and community-programs (i.e. meals on wheels). Many IHSS consumers are high functioning and require minimal care coordination, while other consumers will benefit from having their medical and social services coordinated. Thus, the pilots should explore tiered approaches to care coordination through contracts with the County. Option 3: Health Plans could contract with the county to establish ADRC or ADRC-type services. The benefit of this model is that it provides a "medical and social" home for care coordination whereby multiple services can be coordinated. An example of an innovative and effective approach that the State could support and fund via the Integrating entity contracts are local county Aging and Disability Resource Centers (ADRC's). ADRC's, or ADRC-type approaches, can provide the "home" for care coordination teams that include IHSS, MSSP, Triple A's and other community supports, and can serve as a bridge between Integrating Entities and county-based and community-based social service programs.

Page 9 – Supplementary Benefits

- We recommend stronger language to ensure Demonstration sites offer supplementary benefits not covered under Medi-Cal and/or Medicare that are integral to helping persons remain in their home and communities. The list should also be expanded to include social services and supports noted by consumers and providers to be critical, such as access to housing modifications.

Page 9 – Technology

- The RFS should advise applicants that the conversion to CMIPS II may impact the timeline to implement demonstration project.

Page 10 – Appeals

- It is unclear what the impact will be on IHSS appeals processes, rights of the IHSS consumer, and what will be the role of the county and the health plan. We understand this will be clarified in a future proposal and will provide additional feedback at that time.

Page 11 – Medical Loss Ratio

- Rather than waiving the 85/15 medical loss ratio, we recommend that DHCS establish line item in the rate under the 85% medical cost side that would cover the costs of care coordination.

Page 12 – Timeline

- We think the proposed timeline is overly aggressive and needs to build in time for local input and compliance with the Brown Act prior to the deadline to submit applications (currently slated for mid to late February 2012). The timeline doesn't contain any consideration of the time needed at the local level to comply with provisions of the Brown Act prior to approving and submitting letters of support/agreement in partnership with integrating plans as part of the application process. It often takes 4-8 weeks for counties to post documents and agendas to comply with Brown Act requirements. Boards of Supervisors, County Administrative Officials, as well as other local stakeholders should be given an appropriate amount of time to provide input to entities that are interested in applying to become demonstration sites before applications are submitted to DHCS.

Page 18 – D-SNPS

- There are currently only about a dozen D-SNPs in California. We are hearing that some of the C-SNPs are rapidly moving to qualify as a D-SNP. The language in this section should clarify whether applicants must have D-SNP status when they apply or as of the target date to begin enrollment of dual beneficiaries in the integration pilots on January 1, 2013.

Page 20 – County Support

- Counties and Public Authorities strongly support the preservation of consumer rights in the IHSS program to hire, fire, schedule and supervise the IHSS provider. Some health plans have expressed concerns about liability exposure if they are held responsible for tort claims associated with the provision of service by an IHSS provider. Under current law, the state and counties enjoy total immunity from tort claims when IHSS is administered through a local Public Authority. We believe that contract language can be established between demonstration sites and Public Authorities that will address liability concerns and preserve the right of consumers to have the person they want perform personal care assistance. There is also an expectation that IHSS providers may receive training under the dual demonstration pilots. One of the core mandates of the Public Authority is to provide access to

training to IHSS consumers and providers. For these reasons, we believe that demonstration sites should be required to submit a separate letter of agreement from the local IHSS Public Authority must be submitted by the applicant.

Pages 23-24: IHSS

- 1st Bullet – Require 3-year contracts for the course of the demonstration, per our previous comments.
- 3rd bullet – We recommend indicating that sites must be able to articulate how IHSS workers will participate in care teams based on the negotiated discussions with the county program. We recommend adding that sites may contract with counties for additional supports and services beyond the current IHSS program. Examples include but are not limited to: purchasing additional care coordination (tiered case management) and contracting with counties for care coordination to other social services besides IHSS, 7th bullet – The process for purchasing additional service hours needs to be clarified. Does this mean the Demonstration site has the ability to question the county IHSS assessment? Does this mean the Demonstration may increase IHSS hours beyond what is authorized? Additional clarification is needed. Also, when and how will CMIPS be changed to accommodate?
- Professional training of the IHSS worker –
    - The RFS should require demonstration sites to contract with Public Authorities for training of IHSS providers. The RFS should require collaboration between the Public Authority, integrating entity, local IHSS Advisory Committee and exclusive union that represents IHSS providers to 1) identify training and other support needs of personal care providers and create materials, tools and work aids that will enable homecare providers to improve the quality of care and create opportunities for career ladders, and 2) identify training needs of IHSS consumers and develop training, educational materials and other methods of support to help consumers understand how to access and manage personal assistance services as well as other medical and supportive services that are available from the Integrating entity and develop/improve skills required to self-direct their care.
    - Training implies that the providers who are more skilled will be paid higher wages for their services, which is likely to increase costs to the program. Tiered levels of training and certification should be considered.
    - Note that IHSS County Social Work staff currently receive training from the California Department of Social Services via a grant with CSU Sacramento. Will this change in the future, and if so, how?

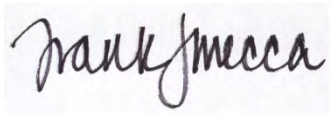
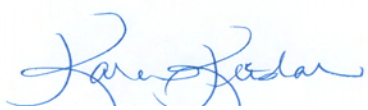
Page 25: Care Coordination

- How will plans establish levels of care coordination, this should be described and expectations articulated, such as timely client access to care coordinators, caseload sizes, etc.

Counties welcome discussion with our State partners to develop a program model that is consumer-focused, client-driven, and which improves the quality of care. Counties believe that a successful Duals Demonstration will result when built on the existing strengths of the IHSS program and county expertise in administering the program and supporting consumers and providers.

Thank you for this opportunity to provide input on the draft Request for Solutions for the four-county dual demonstration pilots.

Sincerely,

Kelly Brooks-Lindsey	Frank Mecca	Karen Keeslar
Senior Legislative Representative	Executive Director	Executive Director
CSAC	CWDA	CAPA

C: Will Lightbourne, Director, CA Department of Social Services
Toby Douglas, Director, CA Department of Health Care Services
Peter Harbage, Harbage Consulting